

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22001

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Faye Alverta KEYSER

2. Date of Death

Month Day Year
June 14, 1997

3. Time of Death

12:20 P.M.

4a. Facility Name (If not institution, give street and number)

8937 Indian Springs Road

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

216-22-8337

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 9, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Frederick10c. City, Town or Location
Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8937 Indian Springs Road

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Polisher

16b. Kind of Business/Industry

Optical Company

17. Father's Name (First, Middle, Last)

James Lincoln Schultz

18. Mother's Name (First, Middle, Maiden Surname)

Goldie P. Baugher

19e. Informant's Name/Relationship (Type, Print)

Betsy Kidd/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9983 Harvest Drive, Frederick, Md. 21702

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brookhill Methodist Cem.

Date

June 18, 1997

20c. Location - City or Town, State

Yellow Springs, Maryland

21. Signature of Funeral Service Licensee

Richard C. Basford M00021

22. Name and Address of Facility

Keeney & Basford Funeral Home
106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. A.S.C.V.D.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Andrew Zarick, Jr.

29c. License number

D35164

29d. Date signed (Month, Day, Year)

June 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Andrew Zarick, Jr., M.D., 1080 West Patrick Street, Frederick, Md. 21701

31. Date filed (Month, Day, Year)

JUN 17 1997

32. Registrar's Signature

Richard C. Basford

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22002

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNIE C. KELLY				2. Date of Death Month July Day 8 Year 1997		3. Time of Death 3:30 pm		
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 218-14-3725		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 29 1919	9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS		10d. Inside City Limits 1 Yes 2 No		
	10e. Street and Number 29 W. WASHINGTON STREET APT. 209				10f. Zip Code 21401		10g. Citizen of What Country? US		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry OUT SIDE THE HOME				
	17. Father's Name (First, Middle, Last) WILLIAM CHASE SR.				18. Mother's Name (First, Middle, Maiden Surname) MARY E. HALL				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CAROLYN CHASE (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 TOLL GATE ROAD OWINGS MILL, MD. 21117				
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS		Date 7/11/97		20c. Location - City or Town, State ANNAPOLIS, MD.		
	21. Signature of Funeral Service Licensee <i>Larry H. Reese</i>				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis - Staph Due to (or as a consequence of): b. Chronic renal failure Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 4 days 2 months Yrs	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NIDDM HyperTension Nephrotic syndrome							23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Joseph N. Freund</i>							
29c. License number 017965		29d. Date signed (Month, Day, Year) 7/8/97							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph N. Freund 205 Adelgaty Ave Annapolis, Md									
31. Date filed (Month, Day, Year) JUL 10 1997		32. Registrar's Signature <i>Jule Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22003

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Althea Mae King

2. Date of Death
Month Day Year

July 3 1997

3. Time of Death

0828a.m.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

214-70-5358

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

39

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Sept. 4 1957 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

624 Wellington Circle

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Black15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Ollie King

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Bryson

19e. Informant's Name/Relationship (Type, Print)

Sylvia Phillips (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29827 Polks Rd. Princess Anne, Md. 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Israels Mem. Cemetery 7-7-97 Princess Anne, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gladys B. Stewart

22. Name and Address of Facility

Stewart Funeral Home
821 West Rd. Salisbury, Md. 2180123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Respiratory Arrest

Due to (or as a consequence of):

5 minutes

b. Acute episode, asthma

Due to (or as a consequence of):

8 hours

c. Pulmonary hypertension

Due to (or as a consequence of):

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sarcoidosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Virginia A. Oulay, MD

29c. License number

D33905

29d. Date signed (Month, Day, Year)

7/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

p.o. box 2018, salisbury, Maryland 21802 - 2018

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

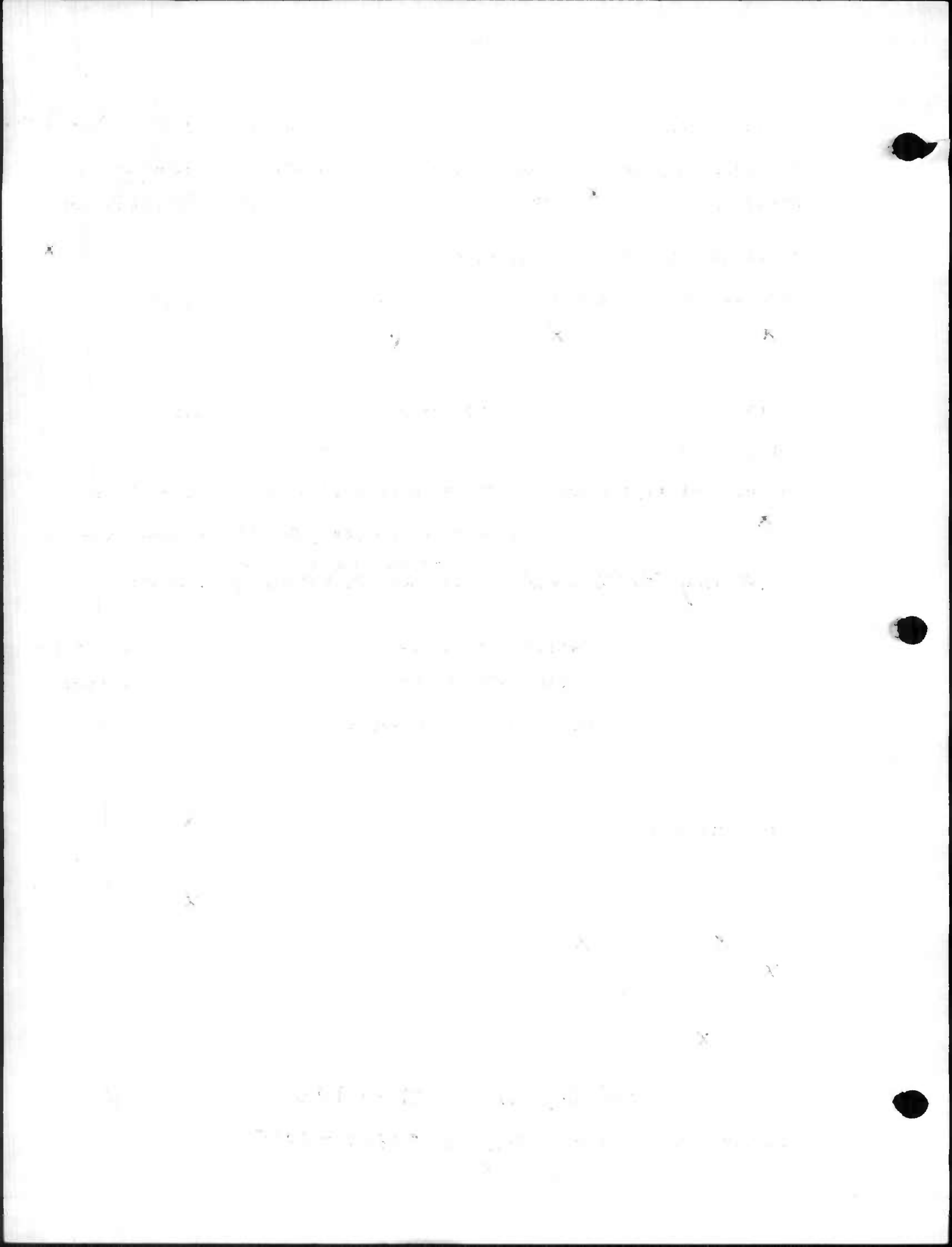
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22004

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY

LOUISE

KELLY

2. Date of Death

Month

Day

Year

3. Time of Death

1830

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

216-16-7159

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
November 16, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1710 S. Kaywood Drive

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Clarence Dryden

18. Mother's Name (First, Middle, Maiden Surname)

Olive Frances Arvey

19a. Informant's Name/Relationship (Type, Print)

Donald L. Kelly/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1600 S. Kaywood Dr., Salisbury, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parsons Cemetery

Date

7/7/97

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

COPD/emphysema

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31546

29d. Date signed (Month, Day, Year)

7/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ignacio L. D. Nardo M.D.

106 Milford St. Salisbury Md.

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

Julia Duvall-Rodall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Mary Kelly
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22005

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Laura Lea Kidd				2. Date of Death Month July Day 9 Year 1997				3. Time of Death 2:50 am	
	4a. Facility Name (If not institution, give street and number) 1758 Travers Wharf Rd.				4b. City, Town, or Location of Death Cambridge				4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 015-34-6458		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 30, 1945		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1758 Travers Wharf Rd.				10f. Zip Code 21613		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 02				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse			16b. Kind of Business/Industry Health Care		
	17. Father's Name (First, Middle, Last) Robert F. Barker				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Lea					
	19a. Informant's Name/Relationship (Type, Print) James S.L. Kidd, Jr. - Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1758 Travers Wharf Rd., Cambridge, MD 21613					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cambridge Crematory		Date 7-9-97		20c. Location - City or Town, State Cambridge, MD			
	21. Signature of Funeral Service Licensee <i>James S.L. Kidd, Jr.</i>				22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Metastatic Duodenal Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>William Bair</i>		29c. License number D43238		29d. Date signed (Month, Day, Year) 7/9/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Bair 19 Franklin St. Cambridge, MD 21613										
31. Date filed (Month, Day, Year) JUL 11 1997										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22006

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HANNAH LUCRETIA LEATHERMAN				2. Date of Death Month Day Year JULY 6, 1997		3. Time of Death 8:00 A.M.	
	4a. Facility Name (If not Institution, give street and number) 13412 UPPER GEORGES CREEK ROAD, SW				4b. City, Town, or Location of Death FROSTBURG		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 213 09 9881	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN 19, 1897		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location FROSTBURG			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 13412 UPPER GEORGES CREEK ROAD, SW				10f. Zip Code 21532		10g. Citizen of What Country? U.S.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) KEELEY FOLK				18. Mother's Name (First, Middle, Maiden Surname) MARY JANE LOGSDON				
19a. Informant's Name/Relationship (Type, Print) ELAINE ANDERSON / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13412 UPPER GEORGES CREEK RD, SW, FROSTBURG, MD 21532				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FROSTBURG MEMORIAL PARK 7/9/97		Date 7/9/97		20c. Location - City or Town, State FROSTBURG, MD 21532		
21. Signature of Funeral Service Licensee <i>Maribou M. Sowers</i>				22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Arteriosclerotic Cardio Vascular Disease</i> Due to (or as a consequence of): b. <i>Concurrent Heart Failure</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 30 yrs 2 yrs.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Angel H. Roque MD</i>						
29c. License number D-13168		29d. Date signed (Month, Day, Year) 07/07/97						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Angel H. Roque, MD, 48 Tarn Terrace, Frostburg, Md. 21532								
31. Date filed (Month, Day, Year) JUL 09 1997								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

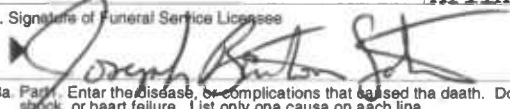
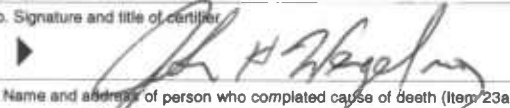

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22007

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DEANN FAYE LESEMANN				2. Date of Death Month July Day 8 Year 1997		3. Time of Death 08:02a.m.
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert
Funeral Director	5. Social Security Number 561-48-1369	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 25, 1937	9. Birthplace (State or Foreign Country) Kansas
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Calvert	10c. City, Town or Location Solomons			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 14748 Patuxent Avenue			10f. Zip Code 20688		10g. Citizen of What Country? U. S. A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Secretary		16b. Kind of Business/Industry Medical Industry		
	17. Father's Name (First, Middle, Last) Homer Creighton			18. Mother's Name (First, Middle, Maiden Surname) Bertha Lee			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Donald F. Lesemann/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14748 Patuxent Avenue Solomons, Maryland 20688			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		Date July	20c. Location - City or Town, State Ft. Myers, Virginia	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 So. Md. Blvd. Owings, Maryland 20736			
	23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. END STAGE CHRONIC MYELOGENOUS LEUKEMIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						
	Approximate Interval Between Onset and Death 13 YEARS						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PLEURONIA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how Injury occurred	
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 			29c. License number D26358		29d. Date signed (Month, Day, Year) JULY 8, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John H Weigel, M.D. Prince Frederick, MD. 20678							
31. Date filed (Month, Day, Year) JUL 09 1997		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22008

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Virginia Larrimore

2. Date of Death

Month Day Year
July 6, 1997

3. Time of Death

7:15 a.m.

4a. Facility Name (If not institution, give street and number)

Pines Springs Mobile Court, Lot #27

4b. City, Town, or Location of Death

Crumpton

4c. County of Death

Queen Annes

Funeral
Director

5. Social Security Number

173-05-7520

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 25, 1917

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Annes

10c. City, Town or Location

Crumpton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Pines Springs Mobile Court, Lot #27

10f. Zip Code

21628

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Food Manufacturer

17. Father's Name (First, Middle, Last)

Robert Earl Brown

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Devitt

19a. Informant's Name/Relationship (Type, Print)

Dolores Sloane

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29 Lee Road 747, Salem, Alabama 36874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

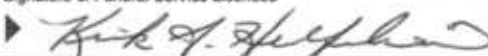
Crumpton Cemetery/July 9, 1997

Data

20c. Location - City or Town, State

Crumpton, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiopulmonary arrest*

Due to (or as a consequence of):

b. *Respiratory Failure*

Due to (or as a consequence of):

c. *End Stage Chronic Obstructive Pulmonary Disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Hypertension, ASCVD, History of Angioplasty
Heart Failure, Anxiety and Depression
Recurrent Pneumonia*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

None

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

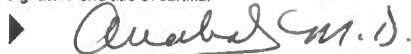
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 23889

29d. Date signed (Month, Day, Year)

7/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John P. Anderson MD, 948 Washington Ave, Chestertown MD 21620

31. Date filed (Month, Day, Year)

JUN 09 '97

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22009

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELVIN S. LONG, SR.

2. Date of Death

Month
June

Day

24, 1997

3. Time of Death

5:10 PM

4e. Facility Name (If not institution, give street and number)

College View Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

219-14-9481

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 31, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hancock

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

14104 Maple Ridge

10f. Zip Code

21750

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction Company

17. Father's Name (First, Middle, Last)

Lowell Lee Long

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Ruth Wagner

19e. Informant's Name/Relationship (Type, Print)

Frances Showe/P.R.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14104 Maple Ridge, Hancock, Maryland 21750

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Mem. Gardens

Date

6/27

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
1201 NORTH MARKET ST., FREDERICK, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26516

29d. Date signed (Month, Day, Year)

June 26 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Allen J. Gilson, MD, 1475 Taney Avenue, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

JUN 27 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22010

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RALPH FRANCIS LIPPS, JR.				2. Date of Death Month Day Year JUNE 23, 1997		3. Time of Death 9:10 PM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-26-7468	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 6, 1931		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 16204 Kelbaugh Road				10f. Zip Code 21788		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1953-55		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Development Engineer			16b. Kind of Business/Industry Worthington Dresser Pumps	
17. Father's Name (First, Middle, Last) Ralph Francis Lipps, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Naomi J. Smith				
19a. Informant's Name/Relationship (Type, Print) Barbara L. Lipps, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16204 Kelbaugh Road Thurmont, Maryland 21788				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem Gardens		20c. Date 6/27/97		20d. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer funeral Homes, P.A. 104 East main street Thurmont, Maryland 21788				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. exsanguination Due to (or as a consequence of): b. excessive non small cell Due to (or as a consequence of): c. ca lung Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 hr 2 mo
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number DR122C		29d. Date signed (Month, Day, Year) JUNE 25, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr Gregory Rausch 501 W. 7th St. Frederick, MD 21701								
31. Date filed (Month, Day, Year) JUN 30 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22011

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eva Maria Lange						2. Date of Death Month Day Year June 22, 1997		3. Time of Death 6:30 AM		
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital						4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 539-30-2879		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) May 2, 1916		9. Birthplace (State or Foreign Country) Germany		
	Usual Residence of Decedent 10a. State Maryland 10b. County Howard 10c. City, Town or Location Mt. Airy 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						10e. Street and Number 1919 Long Corner Road		10f. Zip Code 21771		
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General Administrator		16b. Kind of Business/Industry German Consulate		17. Father's Name (First, Middle, Last) Hans Mankiewicz		18. Mother's Name (First, Middle, Maiden Surname) Alice Sussman Mankiewicz		19a. Informant's Name/Relationship (Type, Print) Angela Jones, daughter		
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Location - City or Town, State 6/24/97 Hagerstown, Maryland		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY EDEMA, ACUTE Due to (or as a consequence of): b. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): c. AORTIC STENOSIS Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 2 hours		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Jonathan Plotzky MD		29c. License number D38589		29d. Date signed (Month, Day, Year) JUNE 21, 1997		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JONATHAN PLOTZKY, MD. 15225 SHADY GROVE ROAD #207 ROCKVILLE		
	31. Date filed (Month, Day, Year) JUN 24 1997		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22012

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) Frances Ann Lewis				2. Date of Death Month Day Year June 22 1997		3. Time of Death 9:53am	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 215-34-1194		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 13, 1939	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 24416 Welsh Road		10f. Zip Code 20882		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Administrative officer		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Government		16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) Estel William Holston				18. Mother's Name (First, Middle, Maiden Surname) Stella Mae Musser			
	19a. Informant's Name/Relationship (Type, Print) Sheila Saunders/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4155 Walnutwood Ct. Mt. Airy Maryland 21771			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Laytonsville Cemetery		20c. Location - City or Town, State 6/25/1997 Laytonsville, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Olin L. Molesworth P.A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Non Small Cell Lung cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number 035635		29d. Date signed (Month, Day, Year) June 22 1997	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph Kneen 1811 Prince Philip Dr. Olney, MD 20832							
31. Date filed (Month, Day, Year) JUN 25 1997				32. Registrar's signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22013

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cora Eva Lambert

2. Date of Death

Month
June

Day

19,

Year

1997

3. Time of Death

4:15 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

217-16-2658

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 16, 1905

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10308 Lenhart Road

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Harry Bluebaugh

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth McCarney

19a. Informant's Name/Relationship (Type, Print)

Franklin H. Lambert/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11250 Hill Road, Keymar, Maryland 21757

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Utica Cemetery

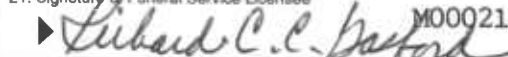
Date

June 21, 1997

20c. Location - City or Town, State

Utica, Maryland

21. Signature of Funeral Service Licensee



M00021

22. Name and Address of Facility

Keeney & Basford Funeral Home

106 East Church Street, Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Urinary tract Infection

Due to (or as a consequence of):

c. Mild Dementia

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D41884

29d. Date signed (Month, Day, Year)

6/19/97

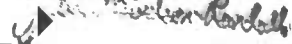
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gerard A. DelGrippe Jr. P.O. Box 310 15 E Frederick St. Walkersville MD 21793

31. Date filed (Month, Day, Year)

JUN 20 1997

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

97 22014

Item: 5 per F.H.G-750 8/22/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH THOMAS LORENZ			2. Date of Death Month July Day 5 Year 1997		3. Time of Death 7:45 AM	
	4a. Facility Name (If not institution, give street and number) 6519 Baily Store Rd.			4b. City, Town, or Location of Death Federalsburg		4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 0858 212-16-0888		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-27-1921
	9. Birthplace (State or Foreign Country) Maryland						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State MD	10b. County Dorchester		10c. City, Town or Location Federalsburg			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 6521 Bailey Store Rd.			10f. Zip Code 21632		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) 1 Year			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Area Foreman		16b. Kind of Business/Industry Anne Arundel County Schools	
	17. Father's Name (First, Middle, Last) Joseph Thomas Lorenz			18. Mother's Name (First, Middle, Maiden Surname) Tilly Augustiniack			
	19a. Informant's Name/Relationship (Type, Print) Joseph Thomas Lorenz, JR.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 558 Allen Rd. Millersville, MD 21108			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cem.		Date 7-9-97	20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Singleton Funeral Home 1 Second Ave. S.W., Glen Burnie, MD 21061			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory arrest Due to (or as a consequence of): b. Metastatic bronchogenic Ca lung Due to (or as a consequence of): Non-small Cell c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Anemia COPD						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 			29c. License number D 10966		29d. Date signed (Month, Day, Year) 7/7/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ann H. Webb, MD 321 Bloomingdale Ave, Federalsburg, MD 21632							
31. Date filed (Month, Day, Year) JUL 10 1997		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22015

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leon Edmond Lewis, Sr.				2. Date of Death Month July Day 10 Year 1997		3. Time of Death 3:55 am	
	4a. Facility Name (If not institution, give street and number) 1816 Hoopersville Road				4b. City, Town, or Location of Death Hoopersville		4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 216-16-7742		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 4, 1920	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Hoopersville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 1816 Hoopersville Road		10f. Zip Code 21634		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waterman		16b. Kind of Business/Industry Shellfish			
	17. Father's Name (First, Middle, Last) James Matthew Lewis, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Floy Windsor			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Spouse Rosa Elizabeth Parks Lewis				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21634 1816 Hoopersville Rd., Hoopersville, MD			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Mem. Pk. 7-12-97		20c. Location - City or Town, State Cambridge, MD		20d. Date 7-12-97	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Prostate CA mets to liver b. Hepatorenal Syndrome c. Cardiomyopathy d. Coronary artery disease				Approximate Interval Between Onset and Death Years. 1 month Years. Years.			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P Pace maker placement				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
	24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number 00050987		29d. Date signed (Month, Day, Year) 7/10/97			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATTMED NAWAZ 105 Aurora Street Cambridge MD							
State Registrar	31. Date filed (Month, Day, Year) JUL 11 1997		32. Registrar's Signature <i>[Signature]</i> 21613					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23b or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22016

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edgar Francis May

2. Date of Death

July 2^{Day} 1997^{Year}

3. Time of Death

2:03 PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

214-16-3016

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 20, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

11472 Ocean Gateway

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Edward Washington May

18. Mother's Name (First, Middle, Maiden Surname)

Mable Allen

19a. Informant's Name/Relationship (Type, Print)

Virginia B. May/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11472 Ocean Gateway, Easton, MD 21601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Cremation

Data

7/7

20c. Location - City or Town, State

Chester, MD

21. Signature of Funeral Service Licensee

JOHN R. MERCERON

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home
200 S. Harrison St., Easton, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiac arrhythmia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

minutes

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

10 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type II diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James Corwin, MD

29c. License number

D33768

29d. Date signed (Month, Day, Year)

July 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Corwin, MD, Daffin Lane, Denton, MD 21629

31. Date filed (Month, Day, Year)

JUL - 7 1997

32. Registrar's Signature

James Corwin, MD

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

97 22017

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT JOSEPH MORRIS				2. DATE OF DEATH MONTH DAY YEAR JULY 4 1997		3. TIME OF DEATH 6:31 AM	
4. SOCIAL SECURITY NUMBER 215-26-6704		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 15 1932	
9a. FACILITY NAME (If not Institution, give street and number) ALLEGANY CO. NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 320 HOLLAND STREET				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES U.S. NAVY 1951-1955		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) KELLY SPRINGFIELD TIRE CO		16b. KIND OF BUSINESS/INDUSTRY TRUCK TIRE BUILDER			
17. FATHER'S NAME (First, Middle, Last) JAMES A. MORRIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) HILDA ELIZABETH MATT			
19a. INFORMANT'S NAME (Type/Print) JEAN MORRIS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE 320 HOLLAND STREET CUMBERLAND MARYLAND 21502					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ROCKY GAP VETERANS CEMETERY JULY 7 1997 FLINTSTONE MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>		22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME RFD 404 DECATUR STREET CUMBERLAND MARYLAND					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC RENAL FAILURE							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. R. Barrera</i>				29c. LICENSE NUMBER D14865		29d. DATE SIGNED (Month, Day, Year) JULY 5, 1997	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. R. BARRERA MEMORIAL HOSPITAL CUMBERLAND MARYLAND							
31. DATE FILED (Month, Day, Year) JUL 07 1997				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22018**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth M. Miller

2. Date of Death

Month Day Year
JULY 7 1997

3. Time of Death

5:20 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

214-05-8651

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Mar 25, 1916

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

834 Columbia Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Chapman

18. Mother's Name (First, Middle, Maiden Surname)

Catherine (Trapp)

19a. Informant's Name/Relationship (Type, Print)

John F. Miller-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12301 Bedford Road NE Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sunset Memorial Park

Date

07/11

20c. Location - City or Town, State

Cumberland MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Adenocarcinoma of the pancreas

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

two weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicida 4 ☐ Homicida28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

R. J. Barrera

29c. License number

D 14865

29d. Date signed (Month, Day, Year)

JULY 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBUSTIANO BARRERA M.D., MEMORIAL MEDICAL BLDG., CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

John F. Miller

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ELIZABETH MILLER
Division of Vital Records, P.O. Box 68760,

V. 11

112

11

112

11

11

11

11

112

112

11

11

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

112

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22019

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES WANEX MOXEY

2. Date of Death

Month
JULYDay
4Year
1997

3. Time of Death

1500

4a. Facility Name (If not institution, give street and number)

DORCHESTER GENERAL HOSPITAL

4b. City, Town, or Location of Death

CAMBRIDGE

4c. County of Death

DORCHESTER

Funeral
Director

5. Social Security Number

220-03-1163

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

DORCHESTER

10c. City, Town or Location

EAST NEW MARKET

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3724 WARWICK ROAD

10f. Zip Code

21631

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOSEPH WANEX, SR.

18. Mother's Name (First, Middle, Maiden Surname)

ANTOINETTE MICHALSKI

19e. Informant's Name/Relationship (Type, Print)

ANDREW J. MOXEY/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3724 WARWICK ROAD, EAST NEW MARKET, MD 21631

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

OUR LADY OF GOOD COUNSEL

Date

7/7

20c. Location - City or Town, State

SECRETARY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 207,

106 MAIN STREET, EAST NEW MARKET, MD 21631

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Cardiac arrest

e. Due to (or as a consequence of):

CHF

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

Aortic CA

c. Due to (or as a consequence of):

Arrhythmia

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 min

Years

10 Yrs.

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DJD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0050987

29d. Date signed (Month, Day, Year)

7/9/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

AHMED NAWAZ 105 Aurora street Cambridge ms

31. Date filed (Month, Day, Year)

JUL 9 1997

32. Registrar's Signature

John Davidson-Randall

21613

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22020

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED ROMAINE MC CLOSKEY				2. Date of Death Month Day Year July 3, 1997		3. Time of Death 11:30 AM	
	4a. Facility Name (If not institution, give street and number) 55 East Washington Street				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 220-10-3527		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 21, 1918	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 55 East Washington Street				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Clarence Marshall Fouché				18. Mother's Name (First, Middle, Maiden Surname) Jennie Mae Hovis				
19a. Informant's Name/Relationship (Type, Print) Nancy L. Kane				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 West Franklin Street, Hagerstown, Md 21740				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery		Data 07-07-97		20c. Location - City or Town, State Hagerstown, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Atherosclerotic Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Chronic obstructive pulmonary disease								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
29c. License number D26523		29d. Date signed (Month, Day, Year) 7/7/97						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. T. DELAHANTY, M.D. 11110 MEDICAL CENTER ROAD HAGERSTOWN MD 21742								
31. Date filed (Month, Day, Year) JUL 8 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

57 22021

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Clara Louise Madden				2. Date of Death Month Day Year June 25, 1997		3. Time of Death 9:05 P. M.	
4a. Facility Name (If not institution, give street and number) Avalon Manor Nursing Home				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
5. Social Security Number 212-07-1468		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 48		8. Date of Birth (Month, Day, Year) April 30, 1919	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 13021 Clopper Road		10f. Zip Code 21740		10g. Citizen of What Country? USA	
11. Mental Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) none		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none		16b. Kind of Business/Industry none		17. Father's Name (First, Middle, Last) Vernon R. Madden, Sr.	
18. Mother's Name (First, Middle, Maiden Surname) Gladys Louise Unknown		19a. Informant's Name/Relationship (Type, Print) Robert Tracy		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1817 W. Washington Street Hagerstown, Maryland 21740		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery		20c. Date 6/30/97		20d. Location (City or Town, State) Baltimore, Maryland		21. Signature of Funeral Service Licensee Gerald N. Minnich	
22. Name and Address of Facility Funeral Home 305 N. Potomac Street Hagerstown, Maryland 21740		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Cardiac arrest</u> Due to (or as a consequence of): b. <u>Anterior wall Myocardial Infarction</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J. Davidson-Pendall	
29c. License number D 18019		29d. Date signed (Month, Day, Year) June 26, 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vasant Datta 334 Mill Street Hagerstown, Maryland 21740		31. Date filed (Month, Day, Year) JUL 01 1997	
32. Registrar's Signature J. Davidson-Pendall							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22022

Reg. No.

**Physician
/Medical
Examiner**

1. Decedent's Name (First, Middle, Last)

Kevin Arnold Miers

2. Date of Death

Month Day Year
July 4, 1997

3. Time of Death

5:10 pm

4a. Facility Name (If not institution, give street and number)

7700 Yellowstone Way

4b. City, Town, or Location of Death

Derwood

4c. County of Death

Montgomery

**Funeral
Director**

5. Social Security Number

212-92-8036

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

28 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 15, 1969

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7700 Yellowstone Way

10f. Zip Code

20855

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Press Dept.

16b. Kind of Business/Industry

Printing Company

17. Father's Name (First, Middle, Last)

Nicholas Raymond Miers

18. Mother's Name (First, Middle, Maiden Surname)

Jane Rebecca Angell

19a. Informant's Name/Relationship (Type, Print)

Nicholas Miers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7700 Yellowstone Way, Derwood, MD 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Memorial Gardens

Date

7/8/97

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Stauffer Funeral Home
1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

MESO THELIOMA

Approximate Interval Between Onset and Death

4 MONTHS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Joseph M. Haggerty MD

29c. License number

D32407

29d. Date signed (Month, Day, Year)

JULY 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Associates in Oncology/Hematology

9707 Medical Ctr. Dr. #300 Rockville MD 20850

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

[Signature] Andrew Randall

**State
Registrar**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician
/Medical
Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

87 22023

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stanley William MITCHELL				2. Date of Death Month June Day 24 Year 1997		3. Time of Death 8:00 P.M.												
	4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Home				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick												
Funeral Director	5. Social Security Number 213-16-1810		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 6, 1920												
	9. Birthplace (State or Foreign Country) Maryland																		
To Be Completed by Funeral Director	Usual Residence of Decedent																		
	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
	10e. Street and Number 3 West Fifth Street				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.												
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1943-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laboratory Technician		16b. Kind of Business/Industry U.S. Government												
	17. Father's Name (First, Middle, Last) Gorman Mitchell				18. Mother's Name (First, Middle, Maiden Surname) Minnie Unknown														
	19a. Informant's Name/Relationship (Type, Print) Sandra Lee Ruhl / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 West Fifth Street, Frederick, Md. 21701														
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date June 28, 1997		20c. Location - City or Town, State Smithsburg, Md.												
	21. Signature of Funeral Service Licensee <i>Richard C. C. Basford</i> 190021				22. Name and Address of Facility Keeney & Basford Funeral Home 106 East Church St., Frederick, Md. 21701														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:40%; text-align: center;">CANCER LUNG</td> <td style="width:30%; text-align: center;">6 months</td> </tr> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 3em;">{</td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">CHRONIC OBSTRUCTIVE LUNG DISEASE</td> <td style="text-align: center;">Years</td> </tr> <tr> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	CANCER LUNG	6 months	{	Due to (or as a consequence of):		CHRONIC OBSTRUCTIVE LUNG DISEASE	Years	Due to (or as a consequence of):		Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)	CANCER LUNG	6 months																	
{	Due to (or as a consequence of):																		
	CHRONIC OBSTRUCTIVE LUNG DISEASE	Years																	
	Due to (or as a consequence of):																		
	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA																			
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No													
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)															
28f. Location (Street and Number or Rural Route Number, City or Town, State)																			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. Signature and title of certifier <i>Saeed A. Zaidi</i>				29c. License number D43901		29d. Date signed (Month, Day, Year) June 27, 1997													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saeed A. Zaidi, M.D., 801 Toll House Ave., Frederick, Md. 21701																			
31. Date filed (Month, Day, Year) JUN 30 1997		32. Registrar's Signature <i>Julia Davidson-Randall</i>																	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22024

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Louise Martin				2. Date of Death Month Day Year June 18, 1997		3. Time of Death 4:40 PM	
	4a. Facility Name (If not institution, give street and number) 24101 Doreen Drive				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 219-14-8245		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) April 14, 1924	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 24101 Doreen Dr.		10f. Zip Code 20882		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Manager		16b. Kind of Business/Industry County Schools			
	17. Father's Name (First, Middle, Last) Albert C. Graf		18. Mother's Name (First, Middle, Maiden Surname) Treva Wildasin		19a. Informant's Name/Relationship (Type, Print) Orville R. Martin/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24101 Doreen Drive, Gaithersburg, Md. 20882	
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Immanuel Lutheran 6/21/97		20c. Location - City or Town, State Manchester, Md.		20d. Date 6/21/97	
	21. Signature of Funeral Service Licensee Olin L. Molesworth		22. Name and Address of Facility Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872		23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ovarian Cancer		Approximate Interval Between Onset and Death Twelve Years	
To Be Completed by Physician/Medical Examiner	23b. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how Injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Kenneth Milw, MD		29c. License number 033686		29d. Date signed (Month, Day, Year) June 19, 1997	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kenneth Milw, MD		31. Date filed (Month, Day, Year) JUN 20 1997		32. Registrar's Signature John Andrew Randall		18111 Prince Philip Dr. #327, Olney, Md. 20832	

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22025

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Larmay McCormick				2. Date of Death Month: July, Day: 3, Year: 1997		3. Time of Death 8:25 am																											
	4e. Facility Name (If not institution, give street and number) Chesapeake Hospice House				4b. City, Town, or Location of Death Linthicum		4c. County of Death Anne Arundel																											
Funeral Director	5. Social Security Number 354-18-2459		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) July 25, 1918																											
	9. Birthplace (State or Foreign Country) Ill		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Riva																											
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3073 Riva Road		10f. Zip Code 21140		10g. Citizen of What Country? USA																											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+) _____		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Travel Agent		16b. Kind of Business/Industry Self-Employed																													
	17. Father's Name (First, Middle, Last) Joseph Larmay				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Bradford																													
	19a. Informant's Name/Relationship (Type, Print) Kathleen Kirschner/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3073 Riva Road, Riva, MD 21140																													
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date July 5, 1997		20c. Location - City or Town, State Baltimore, MD																											
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146																													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Cardiovascular Accident</u></td> <td rowspan="4">Approximate Interval Between Onset and Death <u>7 mos.</u></td> </tr> <tr> <td>b. _____</td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. <u>Metastatic Breast Cancer</u></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <u>Cardiovascular Accident</u>	Approximate Interval Between Onset and Death <u>7 mos.</u>	b. _____	c. _____	d. <u>Metastatic Breast Cancer</u>																				
	Immediate Cause (Final disease or condition resulting in death)	a. <u>Cardiovascular Accident</u>	Approximate Interval Between Onset and Death <u>7 mos.</u>																															
b. _____																																		
c. _____																																		
d. <u>Metastatic Breast Cancer</u>																																		
<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																														
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																														
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																														
<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how Injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred																										
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																												
<table border="1"> <tr> <td colspan="8">29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="4">29b. Signature and title of certifier </td> <td colspan="2">29c. License number 031557</td> <td colspan="2">29d. Date signed (Month, Day, Year) July 3, 1997</td> </tr> </table>								29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 				29c. License number 031557		29d. Date signed (Month, Day, Year) July 3, 1997												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																		
29b. Signature and title of certifier 				29c. License number 031557		29d. Date signed (Month, Day, Year) July 3, 1997																												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell R Deluca 1600 S. Crain Highway, Suite 602, Crofton Bldg Md. 21061																																		
<table border="1"> <tr> <td colspan="4">31. Date filed (Month, Day, Year) JUL 10 1997</td> <td colspan="4">32. Registrar's Signature </td> </tr> </table>								31. Date filed (Month, Day, Year) JUL 10 1997				32. Registrar's Signature 																						
31. Date filed (Month, Day, Year) JUL 10 1997				32. Registrar's Signature 																														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

97-3674-003

B.K.S

TAMMY MARTZ

Items: 23a part I, 27, 28a-f per MEO G-749 7/28/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22026

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TAMMY

RENEE

MARTZ

2. Date of Death

Month

Day

Year

JULY 3, 1997

3. Time of Death

0449 AM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

212-82-0836

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

27 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

09-07-1969

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND10b. County
ANNE ARUNDEL10c. City, Town or Location
ODENTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

501 BRUCE AVENUE

10f. Zip Code

21113

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

11

N/A

16. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTING

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

JAMES

MILTON

MARTZ. III

18. Mother's Name (First, Middle, Maiden Surname)

MARY

ANETTE

SAUNDERS

19a. Informant's Name/Relationship (Type, Print) (FATHER)

JAMES MILTON MARTZ, III

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 BRUCE AVENUE, ODENTON, MD. 21113

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK

Date

7/8/97

20c. Location - City or Town, State

ELKRIDGE, MD.

21. Signature of Funeral Service Licensee

Michael C. Jaffin

22. Name and Address of Facility SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. AMITRIPTYLINE INTOXICATION

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

XX Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☒ Pending investigation
6 ☒ Could not be determined

28a. Date of Injury

(Month, Day, Year)

found 7/3/97

28b. Time of Injury

found 3:56M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
at residence28f. Location (Street and Number or Rural Route Number, City or Town, State)
501 Bruce Avenue, Odenton, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore H. King, MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Theodore H. King

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

*Julia Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22027**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Dorothy McMullen

2. Date of Death

Month
JulyDay
02Year
1997

3. Time of Death

5:30PM

4a. Facility Name (If not institution, give street and number)

685 Red Cedar Road

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

215-03-7922

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 6 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

685 Red Cedar Road

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Herman Pieper

18. Mother's Name (First, Middle, Maiden Surname)

Eugena Dorguth

19a. Informant's Name/Relationship (Type, Print)

William H. McMullen (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

749 Red Cedar Road Annapolis, Maryland 21401

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Crematory July 10, 1997 Brentwood, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardiac arrhythmia

Due to (or as a consequence of):

b. Generalized atherosclerosis

Due to (or as a consequence of):

c. Type 2 Diabetes

Due to (or as a consequence of):

d.

Immediate

Yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Breast cancer

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Joseph N. Friend, M.D.

D17695

July 03, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph N. Friend, M.D. 205 Ridgley Avenue Annapolis, MD 21401 (410-268-3232)

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

John M. Taylor

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

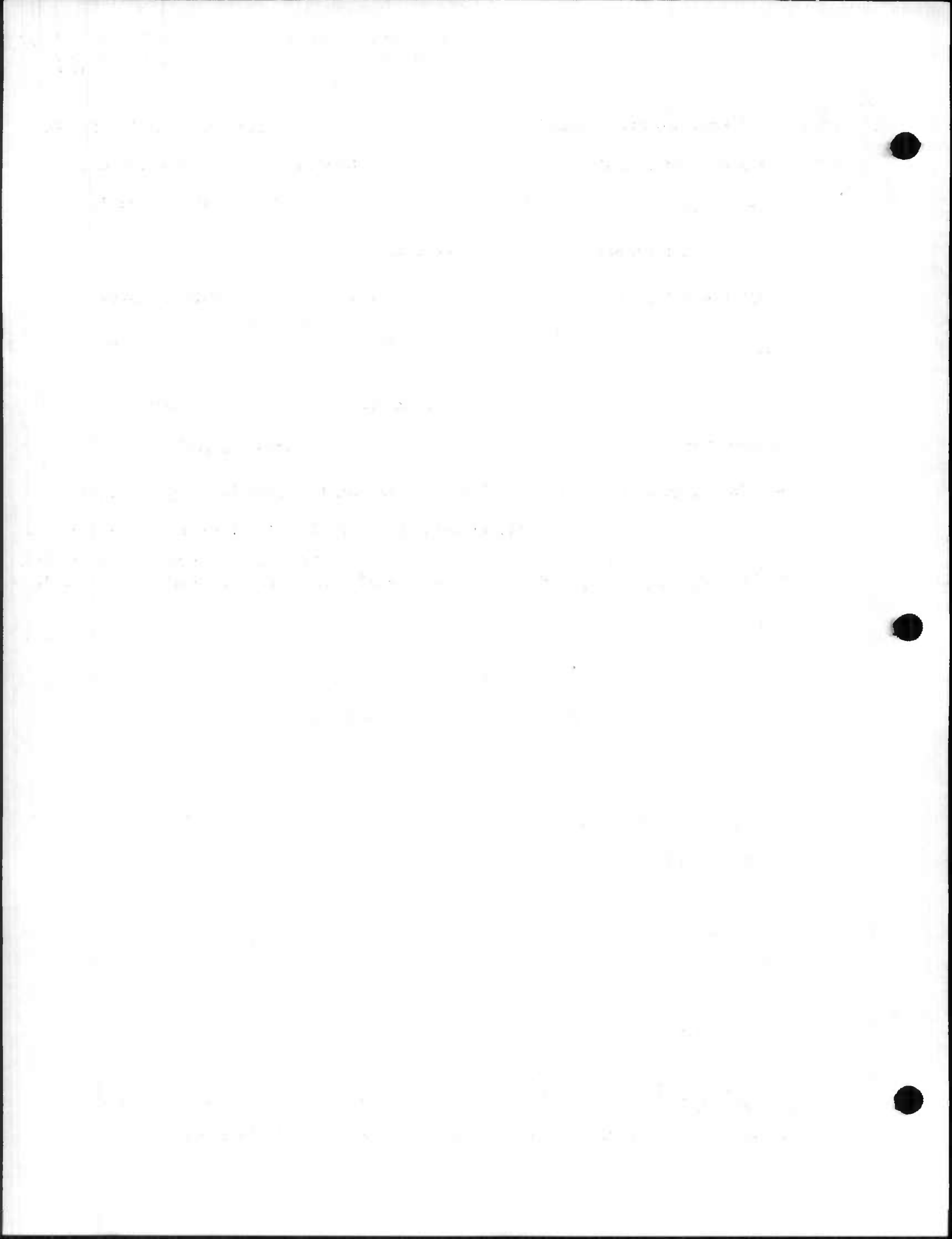
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22028

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FANNIE MASON			2. Date of Death Month JULY Day 6TH Year 1997			3. Time of Death 1:55pm			
	4a. Facility Name (If not institution, give street and number) North Anundel Hospital			4b. City, Town, or Location of Death Glen Burnie			4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 215-32-1135		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 100 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 22 1896		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 2122 MULBERRY HILL ROAD				10f. Zip Code 21401			10g. Citizen of What Country? US			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC			16b. Kind of Business/Industry OUT SIDE THE HOME			
17. Father's Name (First, Middle, Last) WILLIAM WATKINS				18. Mother's Name (First, Middle, Maiden Surname) FANNIE LANE						
19a. Informant's Name/Relationship (Type, Print) HILDA JOHNSON (NEICE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122 MULBERRY HILL RD. ANNAPOLIS, MD. 21401						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS		Date 7/11/97		20c. Location - City or Town, State ANNAPOLIS, MD.			
21. Signature of Funeral Service Licensee Larry H. Reese				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									Approximate Interval Between Onset and Death 4 DAYS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier [Signature], MD			29c. License number D48006			29d. Date signed (Month, Day, Year) JULY 6TH 1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOFI OWUSU-BOATEY, 301 HOSP. DR, GLEN BURNIE, MD 21061										
31. Date filed (Month, Day, Year) JUL 08 1997			32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22029

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Marie Milbourne		2. Date of Death Month July Day 9 Year 1997		3. Time of Death 12:05 p.m.	
4a. Facility Name (If not institution, give street and number) Edw. W. McCready Memorial Hospital			4b. City, Town, or Location of Death Crisfield		4c. County of Death Somerset
5. Social Security Number 212-16-7878	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4-10-1913
9. Birthplace (State or Foreign Country) MD.-U.S.					
Usual Residence of Decedent					
10a. State Md	10b. County SOMERSET	10c. City, Town or Location PRINCESS ANNE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 31365 McCormick Swamp Rd			10f. Zip Code 21853		10g. Citizen of What Country? U.S
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK	
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER			16b. Kind of Business/Industry Domestic		
17. Father's Name (First, Middle, Last) Thomas Boggs			18. Mother's Name (First, Middle, Maiden Surname) Sadie Mae Boggs		
19a. Informant's Name/Relationship (Type, Print) JAMES Milbourne			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21853 31365 McCormick Swamp Rd. Princess Anne Md.		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Marks Cem.		20c. Location - City or Town, State 7/12/97 OAKSVILLE Md.	
21. Signature of Funeral Service Licensee Hulthay E. Ward			22. Name and Address of Facility 30639 Hampden Ave. Princess Anne Md 21853		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure Due to (or as a consequence of): Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier [Signature]		29c. License number D 48098		29d. Date signed (Month, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Vijay Karumbunathan, McCready Hospital, Crisfield, Md. 21817					
31. Date filed (Month, Day, Year) JUL 11 1997		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

CATHERINE NEWMAN

97 22030

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine D. Newman

2. Date of Death

Month Day Year
JULY 05 1997

3. Time of Death

7:00 AM

4e. Facility Name (If not institution, give street and number)

9228 CHERRY LANE

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

214-68-7643

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 3, 1956

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

9228 Cherry Ln

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

James R. Newman Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Williams

19a. Informant's Name/Relationship (Type, Print)

Dorothy Newman / Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5719 Builer St, Capital Heights MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Mem. Park

Date

July 10, 97

20c. Location - City or Town, State

Landover Maryland

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

Adams Funeral Home, Aquasco MD 20608

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bunk fire & penetrating injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☒ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

7-5-97

28b. Time of Injury

0300 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject beaten & stabbed

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9228 Cherry Lane Laurel

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 06, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 11 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22031

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernice Norfleet				2. Date of Death Month 7 - Day 2 - Year 97				3. Time of Death 0005	
	4a. Facility Name (If not institution, give street and number) Dorchester General Hospital				4b. City, Town, or Location of Death Cambridge				4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 250-40-8238		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) May 3, 1924		9. Birthplace (State or Foreign Country) South Carolina	
	Usual Residence of Decedent				10f. Zip Code 21613		10g. Citizen of What Country? USA			
10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 411 Cedar Street				10f. Zip Code 21613				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer				16b. Kind of Business/Industry Farm Work		
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Mary Swinson						
19a. Informant's Name/Relationship (Type, Print) Barbara D. Deveaux (cousin)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 69th St., Capital Heights, Maryland 20743						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery		Date 7/11/97		20c. Location - City or Town, State Cambridge, Maryland				
21. Signature of Funeral Service Licensee John A. Prince				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Due to (or as a consequence of): b. Decubitus Ulcers Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 days 1 year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier William Bair				29c. License number 043238		29d. Date signed (Month, Day, Year) 7/2/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 Franklin St. Cambridge, MD 21613; William Bair										
31. Date filed (Month, Day, Year) JUL 11 1997		32. Registrar's Signature William Bair								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-528-2000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22032

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD M. NORRIS, SR.		2. Date of Death Month JULY Day 09 Year 1997		3. Time of Death 8:55 am
	4e. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL		4b. City, Town, or Location of Death EASTON		4c. County of Death TALBOT
Funeral Director	5. Social Security Number 218-03-5915	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) SEPT. 10, 1904		9. Birthplace (State or Foreign Country) MARYLAND		
Usual Residence of Decedent					
10a. State MD		10b. County TALBOT		10c. City, Town or Location EASTON	
10e. Street and Number 7651 WOODLAND DRIVE		10f. Zip Code 21601		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AUDITOR		16b. Kind of Business/Industry STATE OF MARYLAND	
17. Father's Name (First, Middle, Last) JOSHUA E. NORRIS		18. Mother's Name (First, Middle, Maiden Surname) MARIAN HOLMES			
19a. Informant's Name/Relationship (Type, Print) JOYCE A. NORRIS		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7651 WOODLAND DRIVE, EASTON, MD 21601			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY		20c. Location - City or Town, State 7-14 BALTIMORE, MD	
21. Signature of Funeral Service Licensee JOHN R. MERCERON		22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. congestive heart failure Due to (or as a consequence of): b. atrial fibrillation Due to (or as a consequence of): c. aortic regurgitation Due to (or as a consequence of): d. aspiration pneumonia					Approximate Interval Between Onset and Death one month years 3 weeks
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. acute upon chronic renal failure RT Hip fracture cardiovascular disease					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier SYED ALI		29c. License number D46020		29d. Date signed (Month, Day, Year) 7/9/97	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SYED ALI, M.D., 506 IDLEWILD AVENUE, EASTON, MD 21601					
31. Date filed (Month, Day, Year) JUL 10 1997		32. Registrar's Signature [Signature]			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97-22033

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) JAMES R. NICHOLS JR.				2. Date of Death Month Day Year JULY 10 1997		3. Time of Death 6:58 AM	
4a. Facility Name (If not institution, give street and number) Moran Manor Nursing Home				4b. City, Town, or Location of Death Westernport		4c. County of Death Allegany	
5. Social Security Number 217-05-9518		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) June 4 1919	
9. Birthplace (State or Foreign Country) WV.		10a. State Maryland		10b. County Allegany		10c. City, Town or Location Westernport	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number Grande View Apts. Apt. 104		10f. Zip Code 21562		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No WW 2 If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown		15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer Westvaco Corp.		15b. Kind of Business/Industry Paper Manufacture		16. Kind of Business/Industry	
17. Father's Name (First, Middle, Last) James R. Nichols Sr.				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Mitter			
19a. Informant's Name/Relationship (Type, Print) Kathleen Duckworth / Dau.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17821 Duckworth Dr. Rawlings, Md. 21557			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Philos Cemetery		20c. Location - City or Town, State Westernport, Md.		20d. Date 7-12-97	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility BOAL FUNERAL HOME 111 CHURCH ST. WESTERNPORT, MD.			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 1 hour 3 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Cerebrovascular Accident. Hypertension						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D21244		29d. Date signed (Month, Day, Year) 7/10/97	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan M.D. Frostburgh Plaza, Frostburg, Md. 21532							
31. Date filed (Month, Day, Year) JUL 11 1997				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

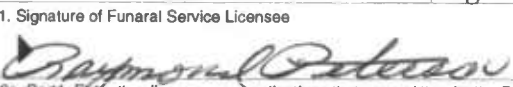


State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22034

Certificate of Death

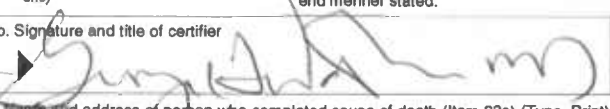
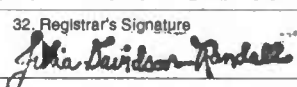
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Keith Bryan Neider				2. Date of Death Month June Day 21 Year 1997		3. Time of Death 12:24 PM		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 528-60-5974		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 15, 1946		
	9. Birthplace (State or Foreign Country) Utah		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1766 Harvest Drive		10f. Zip Code 21702		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 64-68		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Representative		16b. Kind of Business/Industry Printing Supply Co.		17. Father's Name (First, Middle, Last) Clarence William Neider, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Veda Wynona Jensen		19. Informant's Name/Relationship (Type, Print) Julianne Neider / wife	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1766 Harvest Dr. / Frederick, Maryland 21702		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Location - City or Town, State 6-25-97 Hagerstown, Maryland		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility Stauffer Funeral Home		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial Infarction		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier 		29c. License number D30721		29d. Date signed (Month, Day, Year) 6/22/97		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jeffrey N. French MD 310 W 5th St Frederick MD 21701		31. Date filed (Month, Day, Year) JUN 24 1997	
32. Registrar's Signature 		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.		36. To Be Completed by Physician/Medical Examiner	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22035**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEONARD W. NUTHALL				2. Date of Death Month July Day 6 Year 1997		3. Time of Death 11:05pm	
	4a. Facility Name (If not Institution, give street and number) Southern Maryland Hospital Clinton				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 577-50-5704		6. Sex XX M <input type="checkbox"/> F <input type="checkbox"/>	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 8, 1937	9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Upper Marlboro			10d. Inside City Limits XX Yes <input type="checkbox"/> No <input type="checkbox"/>	
10e. Street and Number 9102 Old Burton Circle				10f. Zip Code 20772		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1960-62		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager		16b. Kind of Business/Industry District Creative Printing		
17. Father's Name (First, Middle, Last) Leroy Mortimer Nuthall				18. Mother's Name (First, Middle, Maiden Summa) Lelia Irene Hudson				
19a. Informant's Name/Relationship (Type, Print) Johanna M. Nuthall/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9102 Old Burton Circle Upper Marlboro, Md. 20772				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem'l. Gardens 7-10-97		20c. Location - City or Town, State Davidsonville, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest, Ventricular Fibrillation Due to (or as a consequence of) b. Severe Coronary Artery Disease Due to (or as a consequence of) c. Atherosclerotic Coronary Artery Disease Due to (or as a consequence of) d.								Approximate Interval Between Onset and Death x 18 mo
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes <input checked="" type="checkbox"/> 2 No <input type="checkbox"/> 3 Probably <input type="checkbox"/> 4 Unknown <input type="checkbox"/>		
						24a. Was an autopsy performed? 1 Yes <input type="checkbox"/> 2 No <input checked="" type="checkbox"/>		
						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/>		
25. Was case referred to medical examiner? 1 Yes <input checked="" type="checkbox"/> 2 No <input type="checkbox"/>				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/>		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number 528629		29d. Date signed (Month, Day, Year) 7/7/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George H. Wathen, M.D. 11345 Pembroke Square, Suite 103, Waldorf, Md. 20603								
31. Date filed (Month, Day, Year) JUL 10 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22036

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Carlton Newcomb, Sr.

2. Date of Death
Month Day Year

July 8, 1997

3. Time of Death

6:00 pm

4a. Facility Name (If not institution, give street and number)

William Hill Health Care Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

214-07-7800

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

March 26, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

738 Race Street

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

County Government

17. Father's Name (First, Middle, Last)

Augustine Newcomb

18. Mother's Name (First, Middle, Maiden Surname)

Mollie Fitzhugh

19a. Informant's Name/Relationship (Type, Print)

Mary E. Newcomb - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

738 Race St., Cambridge, MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dorchester Mem. Pk.

Date

7-11-97

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.

308 High St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

e. COPD & Bronchospasm

Due to (or as a consequence of):

10 yrs -

b. Dementia Alzheimer type

Due to (or as a consequence of):

5 yrs -

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

none

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

none

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

29c. License number

215541

29d. Date signed (Month, Day, Year)

7/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WINODRIS MATHIAS, 400 AURORA ST, Cambridge Md 21613

31. Date filed (Month, Day, Year)

JUL 11 1997

32. Registrar's Signature

John Bruckner-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22037

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Joseph O'Brien

2. Date of Death

July 7 Day 1997 Year

3. Time of Death

6:45 AM

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

058-07-6820

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 27 1905

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Port Tobacco

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7615 Carley Dr.

10f. Zip Code

20677

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Program Officer

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Patrick O'Brien

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Jean Kierns O'Brien

19a. Informant's Name/Relationship (Type, Print)

Kathy O'Brien Simms

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 363 Port Tobacco, MD 20677

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crem. 7/8/97

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

David C. Echols MO0945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, INC.

P.O. Box 567 LaPlata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Pneumonia

Due to (or as a consequence of):

b.

Sepsis

Due to (or as a consequence of):

c.

Pseudomonas aeruginosa colitis

Due to (or as a consequence of):

d.

Urosepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration, Protein depletion, Cardiac arrhythmia, Coronary artery disease, Chronic obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David C. Echols

29c. License number

D-08370

29d. Date signed (Month, Day, Year)

7/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Pritchett, MD 118 LaGrange Avenue P.O. Box 1317 LaPlata MD 20646

31. Date filed (Month, Day, Year)

JUL 9 1997

32. Registrar's Signature

Dina Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22038

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANITA LOUISE OLDEN

2. Date of Death

Month
JuneDay
27Year
1997

3. Time of Death

1503

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

215-34-2852

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 14, 1939

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1131 Outer Drive

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0-12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

bakery deli

16b. Kind of Business/Industry

grocery store

17. Father's Name (First, Middle, Last)

Frank Mattax

18. Mother's Name (First, Middle, Maiden Surname)

Birdie Luellen

19a. Informant's Name/Relationship (Type, Print)

Mrs. Lori A. Lushbaugh/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

254 North Colonial Drive, Hagerstown, Maryland 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

July 1, 1997

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Minnich Funeral Home

415 East Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

sudden

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D11266

29d. Date signed (Month, Day, Year)

June 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard N. Weeks, M.D., 580 Northern Avenue, Hagerstown, Maryland 21742

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Brady Orrison

2. Date of Death

Month Day Year
July 3, 1997

3. Time of Death

8:20 PM

4a. Facility Name (If not institution, give street and number)

Vindobona Nursing Home

4b. City, Town, or Location of Death

Braddock Heights Frederick

4c. County of Death

Funeral
Director

5. Social Security Number

212-03-2244

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12/9/08

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1100 Peach Orchard Drive

10f. Zip Code

21716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Eugene Wallace Brady

18. Mother's Name (First, Middle, Maiden Surname)

Emma Reed

19a. Informant's Name/Relationship (Type, Print)

Beatrice Brady Sister in Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

522 Brown Avenue Hagerstown, MD 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

7/5/97

20c. Location - City or Town, State

Hagerstown, Md.

21. Signature of Funeral Service Licensee

Barbara Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home Brunswick, MD 21716

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

PNEUMONIA

Due to (or as a consequence of):

b.

DEMENTIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

24-48 HRS

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERCHOLESTEROLEMIA, OSTEO POROSIS,

COMPRESSION FRACTURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Wayne Richter, M.D.

29c. License number

D16675

29d. Date signed (Month, Day, Year)

7/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wayne Richter, M.D., Brunswick, MD.

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

Ruthie Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22040

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary v. Owens		2. Date of Death July 5 1997		3. Time of Death 2:05 am	
	4e. Facility Name (If not institution, give street and number) Chesapeake Manor Nursing Home		4b. City, Town, or Location of Death Aronld		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 220-16-7778	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76	8. Date of Birth (Month, Day, Year) Feb. 21 1921	9. Birthplace (State or Foreign Country) Maryland	
	10e. State M ARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location LOTHIAN	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1332 MARLBORO ROAD		10f. Zip Code 20711	
	10g. Citizen of What Country? US		11. Marital Status 1 <input type="checkbox"/> Navar Marriad 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Collage (14 or 5+) 0	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC		16b. Kind of Business/Industry OUT SIDE THE HOME		17. Father's Name (First, Middle, Last) JAMES A. TASKER	
	18. Mother's Name (First, Middle, Maiden Surname) CAROL L. DOWNS		19a. Informant's Name/Relationship (Type, Print) BESSIE FRANKLIN (SISTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1332 MARLBORO ROAD LOTHIAN, MD. 20711	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MOSES CEMETERY		20c. Location - City or Town, State 7/9/97 DRURY, MD.	
	21. Signature of Funeral Service Licensee Larry H. Reese		22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Advanced Huntington's Chorea Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Physician /Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Colman M. D. Attending Doctor		29c. License number D21684	
	29d. Date signed (Month, Day, Year) 7.7.97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C.V. CYRIAC M.D. 5109 RIVERVIEW COURT, PASADENA, MD 21122		31. Data filed (Month, Day, Year) JUL 10 1997	
	32. Registrar's Signature John H. ...		33. Registrar's Signature John H. ...		34. Registrar's Signature John H. ...	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

04055-18


SECRET

100 1 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22041

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AUGUST ROBERT PLUTSCHAK				2. Date of Death Month JULY Day 4 Year 1997		3. Time of Death 1:10 PM																													
	4a. Facility Name (If not institution, give street and number) William Hill Health Care				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot																													
Funeral Director	5. Social Security Number 218-14-1951		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) April 18, 1904																													
							9. Birthplace (State or Foreign Country) Maryland																													
Usual Residence of Decedent																																				
10a. State Maryland			10b. County Talbot		10c. City, Town or Location Easton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																												
10e. Street and Number 501 Dutchmans Lane				10f. Zip Code 21601		10g. Citizen of What Country? U.S.A.																														
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Barber			16b. Kind of Business/Industry -----																													
17. Father's Name (First, Middle, Last) Edward Plutschak					18. Mother's Name (First, Middle, Maiden Surname) Augusta Marie Kleinschmidt																															
19a. Informant's Name/Relationship (Type, Print) Fay P. Dyer Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1176 St. Michaels, Maryland 21663																															
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory July 7, 1997		Date		20c. Location - City or Town, State Dover, Delaware																													
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663																															
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																				
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:60%;"> a. Chronic obstructive pulmonary disease Due to (or as a consequence of): b. Tobacco abuse Due to (or as a consequence of): c. Due to (or as a consequence of): d. </td> <td style="width:10%; text-align: center; vertical-align: middle;"> years </td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. Chronic obstructive pulmonary disease Due to (or as a consequence of): b. Tobacco abuse Due to (or as a consequence of): c. Due to (or as a consequence of): d.	years																									
Immediate Cause (Final disease or condition resulting in death)	a. Chronic obstructive pulmonary disease Due to (or as a consequence of): b. Tobacco abuse Due to (or as a consequence of): c. Due to (or as a consequence of): d.	years																																		
<table border="0" style="width:100%;"> <tr> <td style="width:70%;"> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerosis </td> <td style="width:30%;"> 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown </td> </tr> <tr> <td></td> <td> 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> </tr> <tr> <td></td> <td> 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> </tr> </table>									Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerosis	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerosis	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																																			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="8">26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td rowspan="2">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="3">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="6">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>									25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred																													
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)																													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																				
29b. Signature and title of certifier 					29c. License number D25933		29d. Date signed (Month, Day, Year) 7.7.97																													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael D. Crowley M.D. 508 Idlewild Ave. Easton, Maryland 21601																																				
31. Date filed (Month, Day, Year) JUL - 8 1997			32. Registrar's Signature 																																	

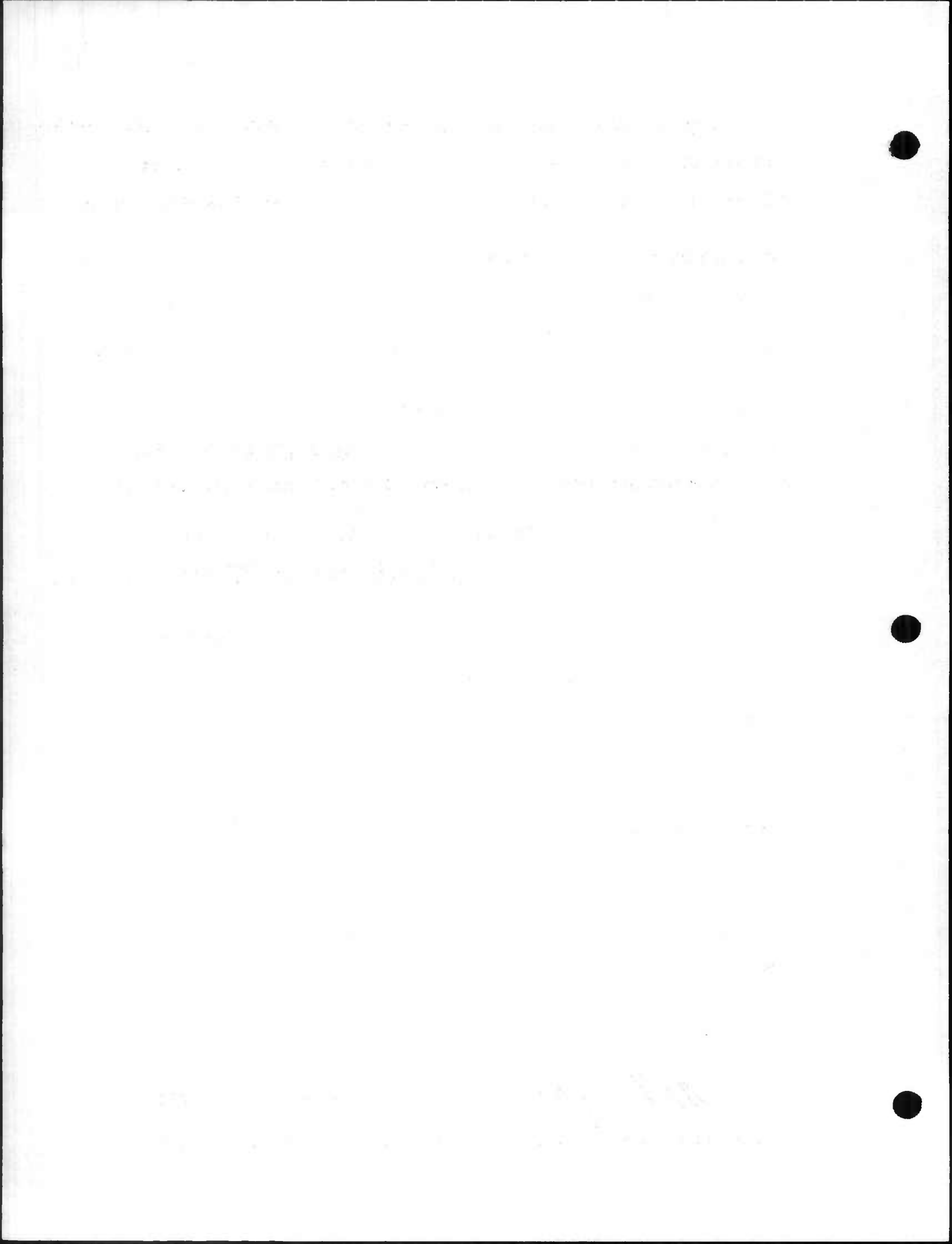
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Reg. No.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22043

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) M. Carol Payne				2. Date of Death Month July Day 9 Year 1997		3. Time of Death 5:17a.m.	
	4a. Facility Name (If not institution, give street and number) 12120 Rock Point Road				4b. City, Town, or Location of Death Rock Point		4c. County of Death Charles	
Funeral Director	5. Social Security Number 011 40 0014	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) March 28 1928		9. Birthplace (State or Foreign Country) Massachusetts
	Usual Residence of Decedent							
10a. State Maryland		10b. County Charles		10c. City, Town or Location Newburg			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 12120 Rock Point Road				10f. Zip Code 20664		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) John Irving Peckham				18. Mother's Name (First, Middle, Maiden Surname) Mary McColgan Peckham				
19a. Informant's Name/Relationship (Type, Print) Virginia P. Maxey (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12120 Rock Point Road Newburg, MD 20664				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Delaney & Sons F.H.		Date 7-10-97		20c. Location - City or Town, State Walpole, Mass 02081		
21. Signature of Funeral Service Licensee  M00173				22. Name and Address of Facility J.H. Eberwein Mortuary 4433 White Pls. La. White Pls., MD 20695				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Cancer of Tonsil, Chronic Pancreatitis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  Dr. Krishan Mathur				29c. License number D28325		29d. Date signed (Month, Day, Year) July 9, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, M.D. - P. O. Box 2729, La Plata, MD 20646								
31. Date filed (Month, Day, Year) JUL 9 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Allen Pearson				2. Date of Death Month Day Year June 28, 1997		3. Time of Death 820p	
	4e. Facility Name (If not institution, give street and number) CAMBRIDGE BELTWAY (ACROSS FROM WOODS CROSSING APTS.)				4b. City, Town, or Location of Death CAMBRIDGE		4c. County of Death DORCHESTER	
Funeral Director	5. Social Security Number 539-96-2835		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 30 Yrs.		8. Date of Birth (Month, Day, Year) April 4, 1967	
	9. Birthplace (State or Foreign Country) Washington		10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 701 Peachblossom Avenue		10f. Zip Code 21613		10g. Citizen of What Country? US	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dishwasher		16b. Kind of Business/Industry Restaurant			
	17. Father's Name (First, Middle, Last) Donald Pearson				18. Mother's Name (First, Middle, Maiden Surname) Nancy Hebert			
	19a. Informant's Name/Relationship (Type, Print) Sheila Pearson Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Peachblossom Avenue Cambridge, Maryland 21613			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Data 7/8/97		20c. Location - City or Town, State Salisbury, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Hanging</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day Year) Found 6/28/97 1955 HR		28b. Time of Injury 1955 HR		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred Subject hanged self				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tree in wooded area near great beltway Cambridge Maryland			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1368 Cambridge							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 30, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year)				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

22045

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Mary Elisabeth Purnell		2. Date of Death Month July Day 8 Year 1997		3. Time of Death 2:40 PM	
4a. Facility Name (If not institution, give street and number) Avalon Manor Nursing Home		4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
5. Social Security Number 218-30-8615	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct 25 1904
9. Birthplace (State or Foreign Country) Allentown, Pa.					
10a. State Md		10b. County Washington		10c. City, Town or Location Hagerstown	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 14014 Marsh Pike		10f. Zip Code 21742		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Scott R. Wagner		18. Mother's Name (First, Middle, Maiden Surname) Anna Lorene Fox			
19a. Informant's Name/Relationship (Type, Print) Lorene P. Baylor		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14721 Honodel Rd, Waynesboro Pa 17268			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cumb. Valley Crem.		20c. Location - City or Town, State Waynesboro, Pa	
21. Signature of Funeral Service Licensee James A. Bowersox		22. Name and Address of Facility Grove Funeral Home, Inc 50 S Broad St Waynesboro Pa 17268			
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Due to (or as a consequence of): Aspiration Due to (or as a consequence of): Senility Due to (or as a consequence of):					
23b. Immediate Cause (Final disease or condition resulting in death) 1 week					
23c. Approximately Interval Between Onset and Death unknown					
23d. Sequence of conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Artherosclerotic Cardiovascular disease					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Denny MD		29c. License number D44996		29d. Date signed (Month, Day, Year) July 9, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAFAR MALIK MD 20311 LAPPANS RD BOONSBORO MD 21713					
31. Date filed (Month, Day, Year) JUL 10 1997		32. Registrar's Signature Jana Davidson-Randall			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

2. In the second part of the paper, the author discusses the problem of the structure of the nucleus. It is shown that the structure of the nucleus is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

3. The third part of the paper is devoted to a discussion of the problem of the structure of the molecule. It is shown that the structure of the molecule is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

4. In the fourth part of the paper, the author discusses the problem of the structure of the crystal. It is shown that the structure of the crystal is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

5. The fifth part of the paper is devoted to a discussion of the problem of the structure of the liquid. It is shown that the structure of the liquid is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

6. In the sixth part of the paper, the author discusses the problem of the structure of the gas. It is shown that the structure of the gas is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

7. The seventh part of the paper is devoted to a discussion of the problem of the structure of the plasma. It is shown that the structure of the plasma is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22046

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louise Broadnaxe Pavlik				2. Date of Death Month July Day 1 Year 1997		3. Time of Death 8:30 AM	
	4a. Facility Name (If not institution, give street and number) 614 Apple Ave.				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 237-05-8727		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 18, 1921	
	9. Birthplace (State or Foreign) Carolina		10a. State Md.		10b. County Frederick		10c. City, Town or Location Frederick	
10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 614 Apple Ave.		10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home				
17. Father's Name (First, Middle, Last) Ebereee Broadnaxe				18. Mother's Name (First, Middle, Maiden Surname) Kate Hardin				
19a. Informant's Name/Relationship (Type, Print) Frank P. Pavlik (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 Apple Ave., Frederick, Md. 21701				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		20c. Date 7/2		20d. Location - City or Town, State Smithsburg, Md.		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769						
23a. Please Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. COPD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D13971		29d. Date signed (Month, Day, Year) 7/2/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L Kaufmann 300 W 9th St Frederick MD 21701								
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22047

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Larry Pulley				2. Date of Death Month July Day 5 Year 1997		3. Time of Death 8:50p.m.	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 217-52-4675		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MARCH 13 1951	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10e. Street and Number 6906 GLEN RIDGE CIRCLE		10f. Zip Code 21061	
	10g. Citizen of What Country? US		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER		16b. Kind of Business/Industry PEPSI COLA COMPANY	
	17. Father's Name (First, Middle, Last) ALPHONSE R. PULLEY SR.				18. Mother's Name (First, Middle, Maiden Surname) AMELIA E. HARRIS			
	19a. Informant's Name/Relationship (Type, Print) ALPHONSE R. PULLEY, SR. (FATHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 236 TERNWING DRIVE ARNOLD, MD. 21012			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS		Date 7/10/97		20c. Location - City or Town, State ANNAPOLIS, MD.	
	21. Signature of Funeral Service Licensee Larry D. Reese				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acquired immunodeficiency syndrome. AIDS b. HIV infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Hepatitis B d. Acute renal failure							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute hepatic failure & encephalopathy sepsis Acute renal failure							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier Koua M.D.				29c. License number D42219		29d. Date signed (Month, Day, Year) 7/5/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Koua, I. O., 4306 PINEFIELD CT, RANOLDSTOWN, MD 21133.							
	31. Date filed (Month, Day, Year) JUL 08 1997				32. Registrar's Signature Jane Davidson-Randall			
	State Registrar							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended #5, 7/9/97
Phd, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22048

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Violet Loretta Rounds				2. Date of Death Month Day Year JUNE 30, 1997				3. Time of Death 1830			
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany			
Funeral Director	5. Social Security Number 217-34-6249 217-34-6249		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) May 23, 1922		9. Birthplace (State or Foreign Country) Maryland			
	10e. State Md		10b. County Allegany		10c. City, Town or Location Barton		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number P.O. Box 123 High St				10f. Zip Code 21521		10g. Citizen of What Country? United States					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home							
	17. Father's Name (First, Middle, Last) Walter Broadwater				18. Mother's Name (First, Middle, Maiden Surname) Sara Wilt							
	19e. Informant's Name/Relationship (Type, Print) Dale Rounds/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19112 S. Eutaw St. Barton Md. 21521							
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Lawn Mem. Gardens		Data 7/3/97		20c. Location - City or Town, State Lavale, Md.					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Md. 21562									
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute respiratory failure Due to (or as a consequence of): b. pulmonary fibrosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death Hours 2 years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. stroke syndrome heart failure										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 1703459		29d. Date signed (Month, Day, Year) July 1, 1997						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 902 SETON DRIVE, CUMBERLAND, Md 21502												
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22049

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel Gaynell Renner

2. Date of Death

Month Day Year
July 4 1997

3. Time of Death

0400

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

219-01-7494

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 30, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11 S. Walnut Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

supply

16b. Kind of Business/Industry

Washington County Hospital

17. Father's Name (First, Middle, Last)

Vachel Worthington Randell

18. Mother's Name (First, Middle, Maiden Surname)

Susan Gossard

19a. Informant's Name/Relationship (Type, Print)

Helen L. Glessner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16718 Virginia Avenue Williamsport, Maryland 21795

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Memorial Park

Date

7/8/97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Gerald N. Minnich

22. Name and Address of Facility

Gerald N. Minnich
Funeral Home

305 N. Potomac Street

Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. *Third degree Myocardial infarction with Bradycardia* 4 days

Due to (or as a consequence of):

b. *Coronary heart disease* 7 days

Due to (or as a consequence of):

c. *Myocardial infarction, acute* 7 days

Due to (or as a consequence of):

d. *Myocardial infarction, past* many years

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edna Moody

29c. License number

D02857

29d. Date signed (Month, Day, Year)

7/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Moody 1190 Mt. Aetna Rd Hy. Md.

31. Date filed (Month, Day, Year)

JUL 7 1997

32. Registrar's Signature

*Julia Davidson-Randell*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22050

Certificate of Death

Reg. No.

Russell, Donald R.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Donald Raymond RUSSELL				2. Date of Death Month July , Day 1 , Year 1997				3. Time of Death 16:04 PM					
4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown				4c. County of Death Washington					
5. Social Security Number 705-14-0293		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) July 1 1924		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent													
10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 829 Virginia Avenue				10f. Zip Code 21740				10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineering Assistant				16b. Kind of Business/Industry Electric Company					
17. Father's Name (First, Middle, Last) George Hudson Russell						18. Mother's Name (First, Middle, Maiden Surname) Madeline Bower							
19a. Informant's Name/Relationship (Type, Print) Caroline Russell Palkovitz						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13626 Donnybrook Drive Hagerstown, Md. 21742							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		Data 7/5/97		20c. Location - City or Town, State Hagerstown, Maryland					
21. Signature of Funeral Service Licensee Scott Minnich						22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ruptured Abdominal Aortic Aneurysm 1 day Due to (or as a consequence of): b. Arteriosclerotic Cardiovascular Due to (or as a consequence of): c. Disease Due to (or as a consequence of): d.													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure Respiratory Failure													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier [Signature] MD				29c. License number D18127		29d. Date signed (Month, Day, Year) 7/1/97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) C.C. Sullivan MD, 370 Mill St. Hagerstown MD 21740													
31. Date filed (Month, Day, Year) JUL 3 1997				32. Registrar's Signature [Signature]									

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

97 22051

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Laverne Rudisill

2. Date of Death

Month Day Year
June 29, 1997

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Frederick Health Care Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

214-34-9536

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 13, 1911

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

633 Marion Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Marvin L. Kaniper

18. Mother's Name (First, Middle, Maiden Surname)

Amelia O. Clowes

19a. Informant's Name/Relationship (Type, Print)

Herbert C. Rudisill

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Route 2 Box 3012 Inwood, West Virginia 25428

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rose Hill Cemetery 2/7/97

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gerald N. Minnich 305 N. Potomac Street
Funeral Home Hagerstown, Maryland 2174023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 month

b. Hypertension

Due to (or as a consequence of):

Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D43091

29d. Date signed (Month, Day, Year)

7-2-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAEED ZAIDI MD 801 TOLL HOUSE AVE, FREDERICK, MD

31. Date filed (Month, Day, Year)

JUL 7 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22052

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lawrence Pittman RITTER

2. Date of Death

Month

Day

Year

June

28, 1997

3. Time of Death

12:55

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

214-09-8231

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 15, 1909

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

289 Frederick Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

salesman

16b. Kind of Business/Industry

auto

17. Father's Name (First, Middle, Last)

Walter W. Ritter

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Aleshire

19a. Informant's Name/Relationship (Type, Print)

Gloria Flook - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21435 Blackrock Rd., Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rose Hill Cemetery

Data

7-1-97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Mennel

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Coronary Artery Disease

Due to (or as a consequence of):

Coronary Artery Disease

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Due to (or as a consequence of):

Myocardial infarction

Approximate Interval Between Onset and Death

2 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung cancer obstructed by blood

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. R. Fiddler

29c. License number

770 6041

29d. Date signed (Month, Day, Year)

6-30-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

E. R. Fiddler 382 John Street, Hagerstown, Md 21740

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

John Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THEODORE STERLING ROGERS, JR				2. Date of Death Month Day Year JUNE 25, 1997		3. Time of Death 0910AM	
	4a. Facility Name (If not institution, give street and number) ROUTE #64				4b. City, Town, or Location of Death SMITHSBURG		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 594-14-2617	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 23 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUL 24, 1973		9. Birthplace (State or Foreign Country) Yuma, Arizona
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State PA	10b. County FRANKLIN	10c. City, Town or Location WAYNESBORO			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 7 PEN MAR STREET			10f. Zip Code 17268		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOCK SUPERVISOR			16b. Kind of Business/Industry TRUCKING COMPANY		
	17. Father's Name (First, Middle, Last) THEODORE STERLING ROGERS, SR				18. Mother's Name (First, Middle, Maiden Surname) DELORES JOHNSON			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) THEODORE S. ROGERS, SR			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 PEN MAR ST WAYNESBORO PA 17268				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BURNS HILL CEMETERY		Date 6/30/97		20c. Location - City or Town, State WAYNESBORO PA 17268	
	21. Signature of Funeral Service Licensee James A. Bowersox			22. Name and Address of Facility GROVE FUNERAL HOME, INC 50 S BROAD ST WAYNESBORO PA 17268				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 6-25-97		28b. Time of Injury 0810 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Driver in auto accident
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street						28f. Location (Street and Number or Rural Route Number, City or Town, State) Rte 64 (Woj Ingram Rd)
29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JUNE 26, 1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. [Signature] 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUN 30 1997		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22054

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Eugene Riddlemoser

2. Date of Death

Month Day Year
June 30, 1997

3. Time of Death

7:15 P.M.

4a. Facility Name (If not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

214-10-2665

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 2, 1906 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Frederick10c. City, Town or Location
Frederick

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

610 Schley Ave.

10f. Zip Code

21701

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Self

16b. Kind of Business/Industry

Butcher

17. Father's Name (First, Middle, Last)

Howard Eugene Riddlemoser

18. Mother's Name (First, Middle, Maiden Surname)

Emma Florence Keller

19a. Informant's Name/Relationship (Type, Print)

Doris Bottcher, step-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 Wyngate Dr., Frederick, MD 21701

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

7/3/97

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, MD 21702

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D13971

29d. Date signed (Month, Day, Year)

7/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 West 9th Street Frederick md

31. Date filed (Month, Day, Year)

JUL 02 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

1914

1914

1914

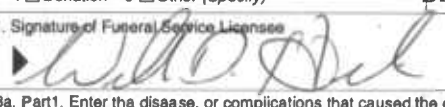
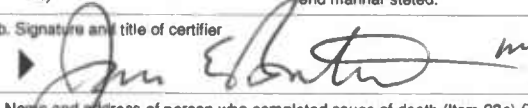
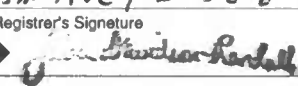
1914

1914

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22055

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harold Irvin Rebuck				2. Date of Death Month Day Year June 16 1997		3. Time of Death 2:15 am									
	4a. Facility Name (If not institution, give street and number) 17301 Hoskinson Road				4b. City, Town, or Location of Death Poolesville		4c. County of Death Montgomery									
Funeral Director	5. Social Security Number 161-28-7952		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 4 1935	9. Birthplace (State or Foreign Country) PA								
	Usual Residence of Decedent				10e. State MD		10b. County Montgomery									
To Be Completed by Funeral Director	10c. City, Town or Location Poolesville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 17301 Hoskinson Rd.									
	10f. Zip Code 20837				10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced									
	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1954/96				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Natl Disaster Med System USPHS		16b. Kind of Business/Industry									
	17. Father's Name (First, Middle, Last) Irvin Melvin Rebuck				18. Mother's Name (First, Middle, Maiden Surname) Clara Kiehl											
	19a. Informant's Name/Relationship (Type, Print) Sally G Rebuck wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17301 Hoskinson Rd. Poolesville, MD 20837											
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg		Date 6/17		20c. Location - City or Town, State Smithsburg, MD									
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hilton Funeral Home Barnesville, MD 20838											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. LIVER METASTASIS</td> <td>Approximate Interval Between Onset and Death 3 WEEKS</td> </tr> <tr> <td>b. PANCREATIC CANCER</td> <td>3 WEEKS</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. LIVER METASTASIS	Approximate Interval Between Onset and Death 3 WEEKS	b. PANCREATIC CANCER	3 WEEKS	c.		d.
Immediate Cause (Final disease or condition resulting in death)	a. LIVER METASTASIS	Approximate Interval Between Onset and Death 3 WEEKS														
	b. PANCREATIC CANCER	3 WEEKS														
	c.															
	d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. Signature and title of certifier 				29c. License number D 50308		29d. Date signed (Month, Day, Year) JUNE 16, 1997										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NANCY 8901 WISCONSIN AVE, BLDG 8 RM 5101, BETHESDA MD 20889																
31. Date filed (Month, Day, Year) JUN 18 1997				32. Registrar's Signature 												

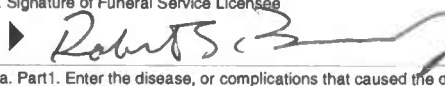
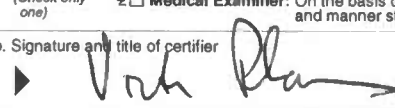
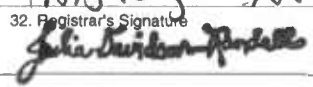
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22056

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alyda Gibbs Rowles				2. Date of Death Month July Day 5 Year 1997		3. Time of Death 1:30 pm													
	4a. Facility Name (If not institution, give street and number) 11 Linstead Road				4b. City, Town, or Location of Death Severna Park		4c. County of Death Anne Arundel													
Funeral Director	5. Social Security Number 216-46-5449		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 18, 1906													
	9. Birthplace (State or Foreign Country) MD																			
Usual Residence of Decedent																				
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severna Park			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
10e. Street and Number 11 Linstead Road				10f. Zip Code 21146		10g. Citizen of What Country? USA														
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 years College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Elementary School														
17. Father's Name (First, Middle, Last) John Henry Gibbs					18. Mother's Name (First, Middle, Maiden Surname) Magdalene Barbara Schuerholz															
19a. Informant's Name/Relationship (Type, Print) Rusty Rowles/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Linstead Road Severna Park, MD 21146																
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date July 7 1997		20c. Location - City or Town, State Baltimore, MD													
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Barranco & Sons Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:60%;">a. breast CANCER Due to (or as a consequence of):</td> <td style="width:10%;"></td> </tr> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 3em;">{</td> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	a. breast CANCER Due to (or as a consequence of):		{	b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
Immediate Cause (Final disease or condition resulting in death)	a. breast CANCER Due to (or as a consequence of):																			
{	b. Due to (or as a consequence of):																			
	c. Due to (or as a consequence of):																			
	d. Due to (or as a consequence of):																			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No													
			28d. Describe how Injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)														
			28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier 				29c. License number 028686		29d. Date signed (Month, Day, Year) 7/7/97														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1509 Ritchie Highway Arnold, Md 21012																				
31. Date filed (Month, Day, Year) JUL 10 1997			32. Registrar's Signature 																	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

State
Registrar

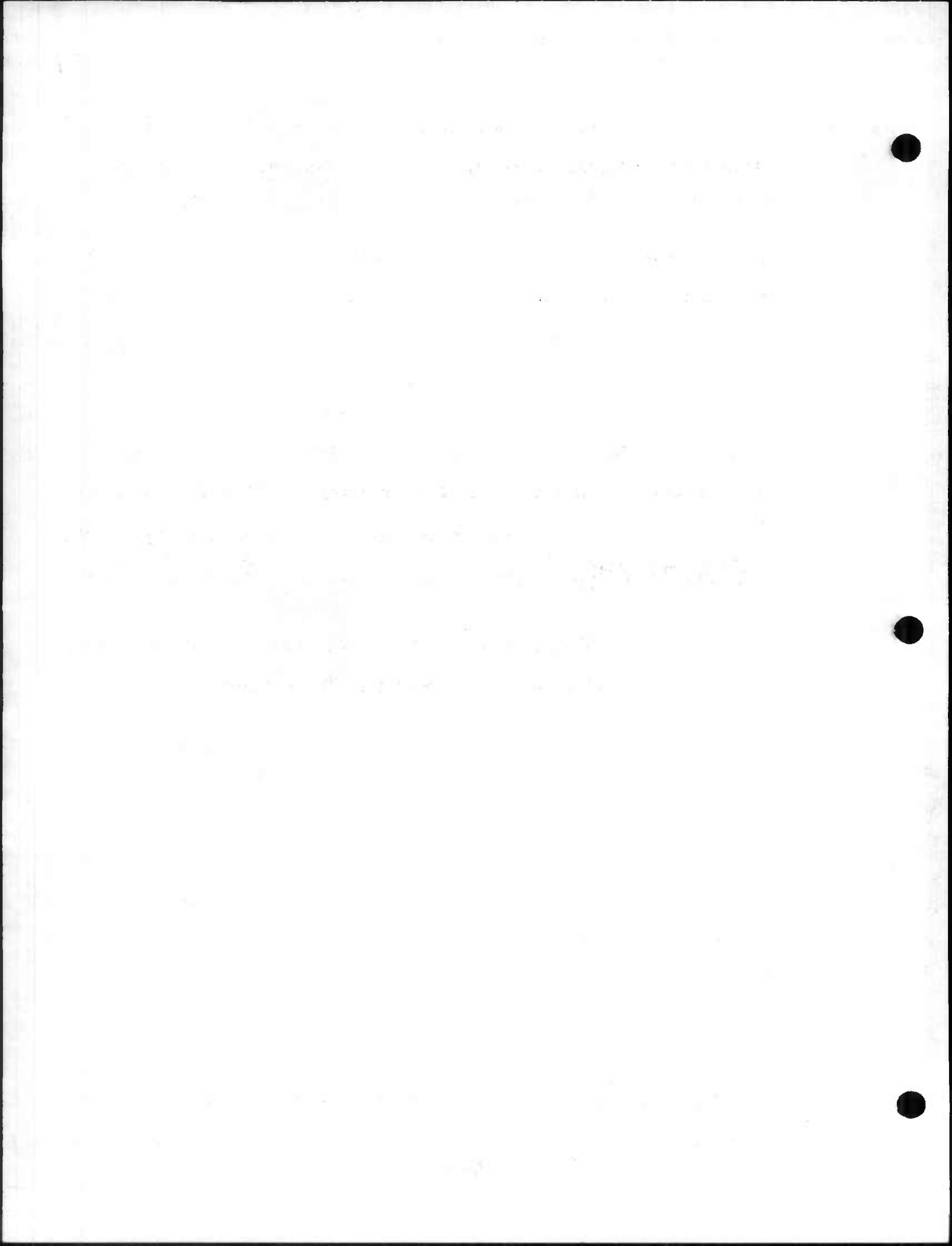
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22057

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nellie K. Rockefeller				2. Date of Death Month Day Year July 4 1997		3. Time of Death 0700	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 578-18-0667		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 11, 1920	
	9. Birthplace (State or Foreign Country)							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MD		10b. County Wicomico		10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1022 Beaglin Park Dr. Apt 104				10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) Collage		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Legal Secretary		16b. Kind of Business/Industry Law Firm			
	17. Father's Name (First, Middle, Last) Clyde W. Koontz				18. Mother's Name (First, Middle, Maiden Summa) Elton Jennings			
	19a. Informant's Name/Relationship (Type, Print) Pamela Rockefeller - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35730 Henny Penny Dr. Pittsville, MD 21850			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lacey Spring Cemetery		Data 7-8-97		20c. Location - City or Town, State Lacey Spring, VA.	
	21. Signature of Funeral Service Licensee B. Keith Phyllis, CFSP				22. Name and Address of Facility Bounds Funeral Home Salisbury, MD 21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ruptured abdominal aortic aneurysm Due to (or as a consequence of): b. Abdominal Aortic Aneurysm. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death min.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Stephen Konlan MD		29c. License number D0052039		29d. Date signed (Month, Day, Year) July 4, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen Konlan MD, 560 Riverside Dr. A206 - Salisbury MD, 21804								
31. Date filed (Month, Day, Year) JUL 07 1997		32. Registrar's Signature John Davidson Radell						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22058

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Irene Stanley</i>				2. Date of Death Month <i>7</i> Day <i>7</i> Year <i>97</i>		3. Time of Death <i>1957 hr</i>																		
	4a. Facility Name (If not institution, give street and number) <i>Dorchester General Hospital</i>				4b. City, Town, or Location of Death <i>Cambridge</i>		4c. County of Death <i>Dorchester</i>																		
Funeral Director	5. Social Security Number <i>262-22-9209</i>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>81</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <i>10/05/15</i>	9. Birthplace (State or Foreign Country) <i>Fla.</i>																	
	Usual Residence of Decedent																								
To Be Completed by Funeral Director	10a. State <i>MD</i>		10b. County <i>Dorchester</i>		10c. City, Town or Location <i>Cambridge, MD</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																		
	10e. Street and Number <i>928 Washington St</i>				10f. Zip Code <i>21613</i>		10g. Citizen of What Country? <i>USA</i>																		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>																		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Packer</i>		16b. Kind of Business/Industry <i>Phillips Packing Co.</i>																				
	17. Father's Name (First, Middle, Last) <i>Robert McNish</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Alice MORRIS</i>																				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Graham Patricia Daugh</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>928 Washington St, Cambridge, Md. 21613</i>																				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Bethel Cemetery</i>		20c. Location - City or Town, State <i>7/12/97 Cambridge, Maryland</i>																				
	21. Signature of Funeral Service Licensee <i>John A. Quince</i>				22. Name and Address of Facility <i>Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601</i>																				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Cardiac Dysrhythmia</i></td> <td>Approximate Interval Between Onset and Death <i>30'</i></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. <i>End Stage Cardiac Dysfunction</i></td> <td><i>4 yrs</i></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. <i>Arteriosclerotic Cardiovascular Disease</i></td> <td><i>4 yrs</i></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d. <i>Diabetes Mellitus</i></td> <td><i>4 yrs</i></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <i>Cardiac Dysrhythmia</i>	Approximate Interval Between Onset and Death <i>30'</i>	Due to (or as a consequence of):		b. <i>End Stage Cardiac Dysfunction</i>	<i>4 yrs</i>	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. <i>Arteriosclerotic Cardiovascular Disease</i>	<i>4 yrs</i>	Due to (or as a consequence of):		d. <i>Diabetes Mellitus</i>	<i>4 yrs</i>	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. <i>Cardiac Dysrhythmia</i>	Approximate Interval Between Onset and Death <i>30'</i>																							
	Due to (or as a consequence of):																								
	b. <i>End Stage Cardiac Dysfunction</i>	<i>4 yrs</i>																							
	Due to (or as a consequence of):																								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. <i>Arteriosclerotic Cardiovascular Disease</i>	<i>4 yrs</i>																							
	Due to (or as a consequence of):																								
	d. <i>Diabetes Mellitus</i>	<i>4 yrs</i>																							
	Due to (or as a consequence of):																								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>William Todd MD</i>		29c. License number <i>D46111</i>		29d. Date signed (Month, Day, Year) <i>7/7/97</i>																			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>William Todd MD DBH ED Cambridge MD. 21631</i>																									
31. Date filed (Month, Day, Year) <i>JUL 11 1997</i>		32. Registrar's Signature <i>[Signature]</i>																							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

**Physician
/Medical
Examiner**

1. Decedent's Name (First, Middle, Last) Olga P Showell 2. Date of Death Month July Day 8 Year 1997 3. Time of Death 11:40AM

**Funeral
Director**

4a. Facility Name (If not institution, give street and number) UMMS 4b. City, Town, or Location of Death Baltimore 4c. County of Death BALTIMORE

5. Social Security Number 220-52-8770 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) 83 Yrs. 8. Data of Birth (Month, Day, Year) DEC. 31, 1913 9. Birthplace (State or Foreign Country) NEW JERSEY

Usual Residence of Decedent 10a. State FL 10b. County INDIAN RIVER 10c. City, Town or Location VERO BEACH 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 2636 OCEAN DRIVE 10f. Zip Code 32963 10g. Citizen of What Country? USA

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER 16b. Kind of Business/Industry OWN HOME

17. Father's Name (First, Middle, Last) FRANK XAVIER PROBSTING 18. Mother's Name (First, Middle, Maiden Surname) OLGA GOSSER

19a. Informant's Name/Relationship (Type, Print) DEWEES F. SHOWELL/HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6060 HEDGES LANE, EASTON, MD 21601

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CENTER, L.L.C Date 7-9 20c. Location - City or Town, State CHESTER, MD

21. Signature of Funeral Service Licensee M. E. Newnam 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Exsanguination Due to (or as a consequence of): Ischemic cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Adam Clark 29c. License number 29d. Date signed (Month, Day, Year) July 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adam Clark 22 S. Greene St.

**State
Registrar**

31. Date filed (Month, Day, Year) JUL 10 1997 32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22060

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JENNIE WANDA SLOJEWSKA				2. Date of Death Month JULY Day 8 Year 1997		3. Time of Death 7:25 PM	
	4e. Facility Name (If not institution, give street and number) 3884 HARRISON COURT				4b. City, Town, or Location of Death TRAPPE		4c. County of Death TALBOT	
Funeral Director	5. Social Security Number 203-18-3046		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 21, 1906	
	9. Birthplace (State or Foreign Country) POLAND		10e. State MD		10b. County TALBOT		10c. City, Town or Location TRAPPE	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 3884 HARRISON COURT				10f. Zip Code 21673		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CASHIER		16b. Kind of Business/Industry FOOD STORE			
	17. Father's Name (First, Middle, Last) WALENTY SLOJEWSKA				18. Mother's Name (First, Middle, Maiden Surname) JOSEFA CIESLAK			
	19a. Informant's Name/Relationship (Type, Print) JANET McDERMOTT				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 150, TRAPPE, MD 21673			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK		20c. Location - City or Town, State 7-11 SOMERTON, PA.			
	21. Signature of Funeral Service Licensee Joseph M. Ostrowski				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 5 years							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia; Hip fracture							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of injury (Month, Day, Year)								
28b. Time of injury M								
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier J. Hollywood and								
29c. License number D46820								
29d. Date signed (Month, Day, Year) 7/9/97								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JENNIFER HOLLYWOOD, M.D., 607 DUTCHMAN'S LANE, EASTON, MD 21601								
31. Date filed (Month, Day, Year) JUL - 9 1997								
32. Registrar's Signature [Signature]								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22061

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES LOUISE SHARPLESS

2. Date of Death

Month Day Year
JULY 14, 1997

3. Time of Death

9:40 AM

4a. Facility Name (If not institution, give street and number)

GARRETT COUNTY MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

OAKLAND

4c. County of Death

GARRETT

5. Social Security Number

220-34-1607

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 15 1933

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State
MD10b. County
GARRETT10c. City, Town or Location
MT. LAKE PARK

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1200 WHEELING AVENUE

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

ALLEN

TIMMERMAN

18. Mother's Name (First, Middle, Maiden Surname)

ELSIE

MABEL

BITTINGER

19a. Informant's Name/Relationship (Type, Print)

JAMES C. SHARPLESS - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1200 WHEELING AVE.

MT. LAKE PARK, MD 21550

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GARRETT MEMORIAL GARDENS

Date

7/16/97

20c. Location - City or Town, State

OAKLAND, MARYLAND

21. Signature of Funeral Service Licensee

MO0167

22. Name and Address of Facility

P.O. BOX 243
DURST FUNERAL HOME - OAKLAND, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 weeks

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Emphysema

Due to (or as a consequence of):

10 years

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus type II, hypertension

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26650

29d. Date signed (Month, Day, Year)

7/14/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Margaret A. Kaiser, MD, PO Box 486, Oakland, MD 21550

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22062**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) ZOLA-VIRGINIA STEVENSON					2. Date of Death Month July , Day 8 , Year 1997			3. Time of Death 10:57AM	
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL					4b. City, Town, or Location of Death CUMBERLAND			4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 191-28-4482		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Dec 19, 1935		9. Birthplace (State or Foreign Country) PA	
	Usual Residence of Decedant									
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 12914 Sixth Avenue					10f. Zip Code 21502			10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedant Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+)					18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Former Employee			16b. Kind of Business/Industry Restaurant		
17. Father's Name (First, Middle, Last) Lawrence Geisbert					18. Mother's Name (First, Middle, Maiden Surname) Edith (nmn)					
19a. Informant's Name/Relationship (Type, Print) James W. Stevenson-husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12914 Sixth Avenue; Cumberland, MD 21502					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Park		Data 07/11		20c. Location - City or Town, State Cumberland, MD		
21. Signature of Funeral Service Licensee <i>Michael J. Scarpelli</i>					22. Name and Address of Facility Scarpelli Funeral Home Cumberland, MD 21502					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <i>Cardiovascular arrest.</i> Due to (or as a consequence of):</p> <p>b. <i>Ventricular aneurysm</i> Due to (or as a consequence of):</p> <p>c. <i>Dilated cardiomyopathy</i> Due to (or as a consequence of):</p> <p>d. <i>Small Vessel coronary artery disease</i> Due to (or as a consequence of):</p> <p><i>Don't Mary m d On E released body 10/19/97</i></p> </div> <div style="width: 10%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><i>few minutes</i></p> <p><i>unknown</i></p> <p><i>2 years</i></p> <p><i>10 years</i></p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
<div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p><i>Type II Diabetes</i></p> <p><i>Smoker</i></p> </div> <div style="width: 30%;"> <p>23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> </div> </div>										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Released										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>V.R. Felipa M.D.</i>				29c. License number D13601		29d. Date signed (Month, Day, Year) JULY 8th 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V.R. Felipa M.D.; 925 Bishop Walsh Drive; Cumberland, MD 21502										
31. Date filed (Month, Day, Year) JUL 0 8 1997					32. Registrar's Signature <i>Jahid...</i>					

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97 22063

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) EVELYN PEARL SHEETZ				2. DATE OF DEATH MONTH July DAY 10 , YEAR 1997		3. TIME OF DEATH 6:01 am	
4. SOCIAL SECURITY NUMBER 214-05-5264		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 26, 1913	
9a. FACILITY NAME (If not institution, give street and number) DEVLIN MANOR NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION LaVale		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 103 West Street				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired		16b. KIND OF BUSINESS/INDUSTRY Dept. Store			
17. FATHER'S NAME (First, Middle, Last) George F. Sheetz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Edna (Kyne)			
19a. INFORMANT'S NAME (Type/Print) Clarence E. Sheetz-brother				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12603 Irons Mountain Road; Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Memorial Park 07/12		20c. LOCATION — City or Town, State Cumberland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nicholas J. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Adenocarcinoma metastatic							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCD, CHF							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. J. Bollino</i>				29c. LICENSE NUMBER D17565		29d. DATE SIGNED (Month, Day, Year) July 10, 1997	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. J. Bollino MD 855 Frederick St Cumberland MD 21502							
31. DATE FILED (Month, Day, Year) JUL 11 1997				32. REGISTRAR'S SIGNATURE <i>Jane Director</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22064

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna Mae Simpson				2. Date of Death Month Day Year July 5, 1997		3. Time of Death 2:00 P.M.		
	4a. Facility Name (If not Institution, give street and number) Mediplex of Montgomery Village				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 579-22-2123	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 28, 1925	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Clinton			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 6205 Parkview Lane			10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+) N/A		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home				
	17. Father's Name (First, Middle, Last) Jessie Thomas Quillin				18. Mother's Name (First, Middle, Maiden Surname) Enda Mae Howard				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Bernard F. Quillin (Brother)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3530 Hall Creek Lane Owings, Maryland 20736					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland State Veterans Cem. 1997		Date July 9,		20c. Location - City or Town, State Cheltenham, Maryland		
	21. Signature of Funeral Service Licensee Charles L. Bilangee		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory arrest Due to (or as a consequence of): Myotonic Dystrophy Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Possible pneumonia								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier John L. Sarama MD				29c. License number D10493		29d. Date signed (Month/Day/Year) 7/5/97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) C. S. SAIA, 809 Views Mill Rd Rockville MD 20851									
31. Date filed (Month, Day, Year) JUL 09 1997				32. Registrar's Signature Julia Anderson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22065

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL HAROLD SLIFER

2. Date of Death
Month Day Year
July 3 1997
3. Time of Death
23:43

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

220-28-8418

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 16, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Rohrersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20326 Locust Grove Road

10f. Zip Code

21779

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1951-195313. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Correctional Officer

16b. Kind of Business/Industry

State Prison

17. Father's Name (First, Middle, Last)

Luther Beard Slifer

18. Mother's Name (First, Middle, Maiden Surname)

Orpha May Grimm

19a. Informant's Name/Relationship (Type, Print)

Shirley M. Slifer, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20326 Locust Grove Road, Rohrersville, MD 21779

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Boonsboro Cemetery July 7, 1997

Date

20c. Location - City or Town, State

Boonsboro, Maryland

21. Signature of Funeral Service Licensee

P. Steven Danfelt, Jr.

22. Name and Address of Facility

BAST FUNERAL HOME 7606 Old National Pike
Boonsboro, Maryland 2171323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Pancreatic Cancer

Approximate
Interval Between
Onset and Death

ONE MONTH

b.

Due to (or as a consequence of):

MALNUTRITION

c.

Due to (or as a consequence of):

RENAL INSUFFICIENCY

d.

DEHYDRATION

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

SHAHAB Z. SIDDIQUI

29c. License number

D45031

29d. Date signed (Month, Day, Year)

07/05/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Siddiqui 19414 C Luthersburg Pike, Htg. Md. 21742

31. Date filed (Month, Day, Year)

JUL 7 1997

32. Registrar's Signature

Julia Davidson-Rondella

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Paul Harold Slifer

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22066

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEWIS THOMAS SMITH, JR

2. Date of Death

Month
JULYDay
2Year
1997

3. Time of Death

0245

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

217-18-7967

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Jan. 2, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10825 Allen Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1943-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Hospital Domiciliary

17. Father's Name (First, Middle, Last)

Lewis T. Smith, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ethel M. Shrader

19a. Informant's Name/Relationship (Type, Print)

Dorothy E. Smith/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10825 Allen Avenue Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park July 5, 1997 Hagerstown, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home
1331 Eastern Blvd. N. Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pulmonary Fibrosis
Due to (or as a consequence of):

Approximate interval between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. J. A. Smith

29c. License number

D21457

29d. Date signed (Month, Day, Year)

7/2/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ABDUL WATKINS MD - 12821 - OAK HILL AVE. HAGERSTOWN, MD

State
Registrar

31. Date filed (Month, Day, Year)

JUL 7 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

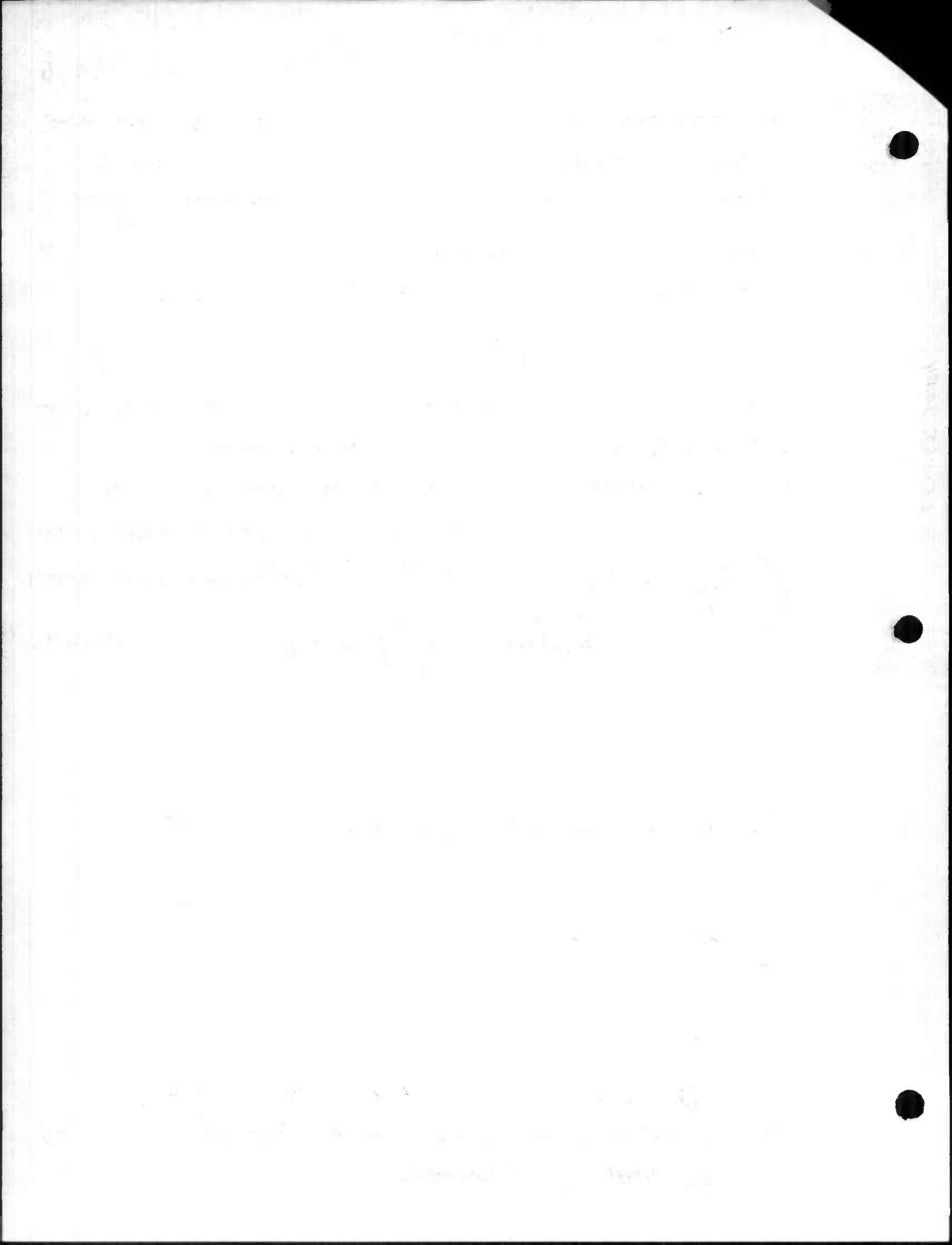
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22067

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Ann SLAUSON						2. Date of Death Month July Day 1 Year 97		3. Time of Death 8:15 pm	
	4e. Facility Name (If not institution, give street and number) 518 S. Cannon Avenue						4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 217-28-5656		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) Sept 13 1932		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 518 S. Cannon Avenue				10f. Zip Code 21740				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse				16b. Kind of Business/Industry Hospital		
17. Father's Name (First, Middle, Last) Grason Doarnberger						18. Mother's Name (First, Middle, Maiden Surname) Mary Virginia Cline				
19a. Informant's Name/Relationship (Type, Print) Philip G. Slauson						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 S. Cannon Avenue Hagerstown, Maryland 21740				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date 7/2/97		20c. Location - City or Town, State Hagerstown, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of):										5-6 hrs
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. atherosclerotic disease Due to (or as a consequence of):										years
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 						
				29c. License number DH1206		29d. Date signed (Month, Day, Year) July 1 97				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) H. N. V. Parks 580 Northview Ave Hagerstown, Md										
31. Date filed (Month, Day, Year) JUL 3 1997				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

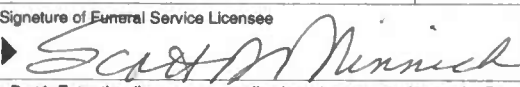
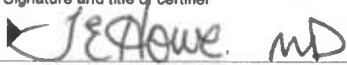
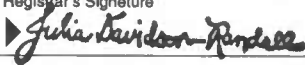
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

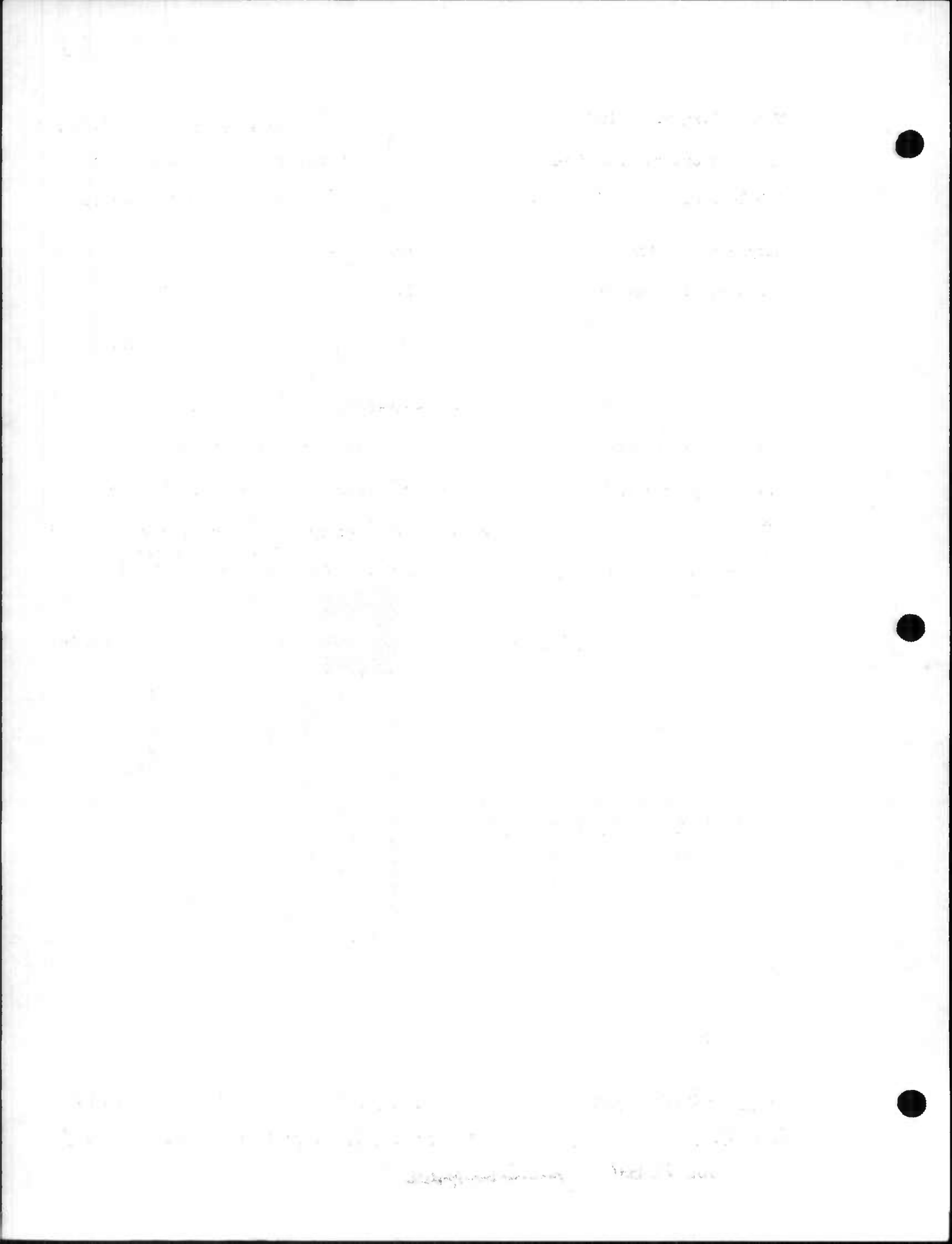
97-22068

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma Virginia SNYDER					2. Date of Death Month Day Year June 29, 1997			3. Time of Death 5:07 p.m.		
	4a. Facility Name (If not institution, give street and number) Williamsport Nursing Home					4b. City, Town, or Location of Death Williamsport			4c. County of Death Washington		
Funeral Director	5. Social Security Number 215-14-2782		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 20, 1914		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 17830 Virginia Avenue				10f. Zip Code 21740		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) legal secretary			16b. Kind of Business/Industry law				
	17. Father's Name (First, Middle, Last) Franklin J. Russell					18. Mother's Name (First, Middle, Maiden Surname) Susan R. unknown					
	19a. Informant's Name/Relationship (Type, Print) Lee G. Snyder - husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17830 Virginia Ave., Hagerstown, Md. 21740						
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Salem Reformed Cemetery		Date 7-3-97		20c. Location - City or Town, State Hagerstown, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p style="font-size: 1.5em; margin-left: 100px;">URO SEPSIS</p> <p style="margin-left: 100px;">Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> <div style="font-size: 3em; margin-left: 100px;">{</div> <p style="margin-left: 100px;">Due to (or as a consequence of):</p> <p style="margin-left: 100px;">Due to (or as a consequence of):</p> <p style="margin-left: 100px;">Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: center;"> <p style="font-size: 1.5em;">4 DAYS</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ADVANCED ALZHEIMER'S DISEASE										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
										24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier  MD					29c. License number D33700			29d. Date signed (Month, Day, Year) July 1, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TED E. HOWE 7542 OVERLOOK DR. BOONSBORO, MD 21713											
31. Date filed (Month, Day, Year) JUL 01 1997										32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22069

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BETTY PATRICIA SMITH				2. Date of Death Month June Day 25 Year 1997		3. Time of Death 1350 pm	
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 108-28-7492	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 28, 1934		9. Birthplace (State or Foreign Country) NEW YORK
	Usual Residence of Decedent				10a. State MARYLAND		10b. County WASHINGTON	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 11 WEST BALTIMORE STREET, APT. 716		10f. Zip Code 21740	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) HOUSEKEEPING DEPARTMENT	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOSPITAL				16b. Kind of Business/Industry HOSPITAL		17. Father's Name (First, Middle, Last) EMILIO FALCONE	
	18. Mother's Name (First, Middle, Maiden Surname) CYNTHIA COLE				19a. Informant's Name/Relationship (Type, Print) GERALD C. SMITH/SPOUSE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 W. BALTIMORE ST., APT. 716, HAGERSTOWN, MD 21740	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY		20c. Location - City or Town, State 6/30/97 BOONSBORO, MARYLAND	
	21. Signature of Funeral Service Licensee Paul M. Dean				22. Name and Address of Facility BAST FUNERAL HOME		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis Due to (or as a consequence of): pneumonia Due to (or as a consequence of): Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier Jacobsonell, MD				29c. License number D47942		29d. Date signed (Month, Day, Year) June 25, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Juan A. Carbonell 12931 Oakhill Avenue, Hagerstown, MD 21742				31. Date filed (Month, Day, Year) JUN 27 1997		32. Registrar's Signature John Davidson-Randall		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

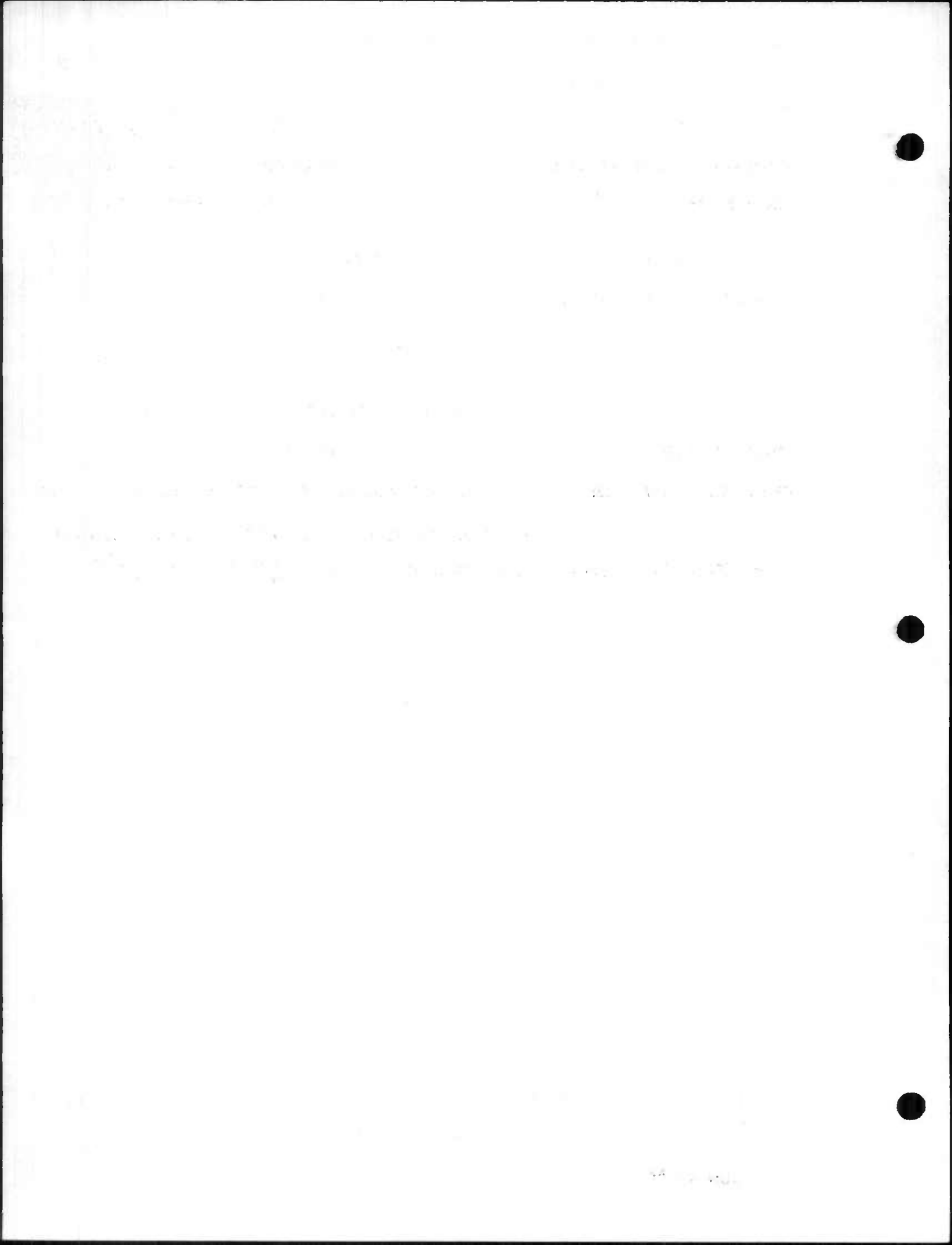
Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

peritonitis

end stage renal failure

Diabetes mellitus



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22070

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT WILLIAM SHUMAKER				2. Date of Death Month Day Year JUNE 25 1997		3. Time of Death 4:00 AM												
	4a. Facility Name (If not institution, give street and number) 303 DELLA LANE				4b. City, Town, or Location of Death BOONSBORO		4c. County of Death WASHINGTON												
Funeral Director	5. Social Security Number 220-26-5838		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 24, 1927												
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County WASHINGTON		10c. City, Town or Location BOONSBORO												
10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 303 DELLA LANE		10f. Zip Code 21713		10g. Citizen of What Country? U.S.A.													
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSURANCE SALESMAN		16b. Kind of Business/Industry LIFE INSURANCE COM.															
17. Father's Name (First, Middle, Last) JOHN WILLIAM SHUMAKER				18. Mother's Name (First, Middle, Maiden Surname) FLORENCE LENA LONG															
19a. Informant's Name/Relationship (Type, Print) JANET I. SHUMAKER/SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 DELLA LANE, BOONSBORO, MARYLAND 21713															
20a. Method of Disposition 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SMITHSBURG CREMATORY		20c. Date 6/25/97		20d. Location - City or Town, State SMITHSBURG, MARYLAND													
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Paul M. Dean BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713																	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Brain Cancer</td> <td>Approximate Interval Between Onset and Death 6 months</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Brain Cancer	Approximate Interval Between Onset and Death 6 months	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):			
Immediate Cause (Final disease or condition resulting in death)	a. Brain Cancer	Approximate Interval Between Onset and Death 6 months																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):																		
	c. Due to (or as a consequence of):																		
	d. Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus																			
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown																			
24a. Was an autopsy performed? 1 Yes 2 No																			
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No																			
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)																	
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No													
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier  MD		29c. License number D44996		29d. Date signed (Month, Day, Year) June 25, 1997															
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ZARER MARIE 26311 Lappans Rd Boonsboro MD 21713																			
31. Date filed (Month, Day, Year) JUN 25 1997		32. Registrar's Signature 																	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

6000.

17. 27.

1000000000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22071

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES Wyatt				2. Date of Death Month July Day 2 Year 1997				3. Time of Death 2:30 P.M.	
	4a. Facility Name (If not institution, give street and number) 12035 Baugher Road				4b. City, Town, or Location of Death Thurmont				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 234-46-0500		6. Sex XXM <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) July 26, 1929		9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 12035 Baugher Road		10f. Zip Code 21788		10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1948-61		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner and Operator	
	16b. Kind of Business/Industry Air Conditioning		17. Father's Name (First, Middle, Last) James W. Sorrells		18. Mother's Name (First, Middle, Maiden Surname) Ila Mae Mason		19a. Informant's Name/Relationship (Type, Print) Johanna P. Sorrells, wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12035 Baugher Road Thurmont, Maryland 21788	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Utica Cemetery		20c. Location - City or Town, State 7/5/97 Utica, Maryland		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 East Main Street Thurmont, MD 21788	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Approximate Interval Between Onset and Death 1 month	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier 		29c. License number D 48184		29d. Date signed (Month, Day, Year) JUL 3, 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Eskander, 501 West Seventh Street, Frederick, MD 21702		31. Date filed (Month, Day, Year) JUL 07 1997	
	32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

97 22072

Item: 19a per FH G-756 2/27/98 dh
Item: 23a part I per MD G-751 9/10/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

BRENT MICHAEL STITELY

2. Date of Death

Month
July

Day

1,

Year

1997

3. Time of Death

4:00 AM

4a. Facility Name (If not institution, give street and number)

8127 Rocky Ridge Road

4b. City, Town, or Location of Death

Thurmont

4c. County of Death

Frederick

5. Social Security Number

215-11-2698

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

13 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 6, 1984

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8127 Rocky Ridge Road

10f. Zip Code

21788

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Middle School

17. Father's Name (First, Middle, Last)

Eugene Gary Stitely

18. Mother's Name (First, Middle, Maiden Surname)

Peggy Louise Long

19a. Informant's Name/Relationship (Type, Print)

Eugene G. Stitely (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8127 Rocky Ridge Road, Thurmont, Maryland 21788

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Graceham Cemetery

Date

7/3

20c. Location - City or Town, State

Graceham, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
615 EAST MAIN ST., THURMONT, MD 2178823a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

EWING SARCOMA WITH PULMONARY METASTASES

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 32245

29d. Date signed (Month, Day, Year)

7/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Amy Jones, MD 56 Thomas Johnson Drive, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

JUL 03 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22073

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Everett SIMONSON

2. Date of Death

Month June 27, Year 1997

3. Time of Death

5:30 A.M.

4a. Facility Name (If not institution, give street and number)

10228 Allview Drive

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

471-30-9813

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 20, 1930

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10228 Allview Drive

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1950-195413. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Automobile Dealership

17. Father's Name (First, Middle, Last)

Simon Alexander SIMONSON

18. Mother's Name (First, Middle, Maiden Surname)

Lillian ARKKOLA

19a. Informant's Name/Relationship (Type, Print)

Karen K. Simonson, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10228 Allview Drive, Frederick, MD 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Smithsburg Crematory, July 2, 1997

Date

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Allan H Ruby 000703

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home
106 East Church Street, Frederick, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. LUNG CANCER
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

MONTHS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

William H. Johnson

29c. License number

D47556

29d. Date signed (Month, Day, Year)

6/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William H. Johnson, M.D. 187 Thomas Johnson Drive, Frederick, MD 21702

31. Date filed (Month, Day, Year)

JUN 30 1997

32. Registrar's Signature

John Davidson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22074

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARENCE JOHN SHULL, SR.

2. Date of Death

Month
JuneDay
25Year
1997

3. Time of Death

6:14 PM

4a. Facility Name (If not institution, give street and number)

Northampton Manor Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

216-22-8117

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 17, 1900

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Northampton Manor N.H.
200 East 16th Street

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Shull's Meat Market

17. Father's Name (First, Middle, Last)

William Hanson Shull

18. Mother's Name (First, Middle, Maiden Surname)

Florence Hargett

19a. Informant's Name/Relationship (Type, Print)

Clarence J. Shull, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2101-1A Whitehall Road, Frederick, Maryland 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Frederick Memorial Park

Date

6/28

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.

1201 NORTH MARKET ST., FREDERICK, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Peripheral Vascular Disease
Due to (or as a consequence of):

years

c. Diabetes Mellitus
Due to (or as a consequence of):

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16428

29d. Date signed (Month, Day, Year)

6/27/97

30. Name and address of person who completed cause of death (Item 25a) (Type, Print)

Casper E. Cline III, MD 300 West Ninth Street, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

JUN 27 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22075

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond Earl Smith, Jr.				2. Date of Death Month Day Year June 21, 1997				3. Time of Death 4:47 AM			
	4e. Facility Name (If not institution, give street and number) 8217 Glendale Dr.				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick			
Funeral Director	5. Social Security Number 214-34-9834		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 19, 1934		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location Maryland Frederick Frederick				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Funeral Director	10e. Street and Number 8217 Glendale Dr.				10f. Zip Code 21702		10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Signal Maintainer		16b. Kind of Business/Industry Railroad							
	17. Father's Name (First, Middle, Last) Raymond E. Smith, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Ruth E. Thomas							
	19e. Informant's Name/Relationship (Type, Print) Shirley Smith, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8217 Glendale Dr., Frederick, MD 21702							
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date 6/24/97		20c. Location - City or Town, State Frederick, Maryland					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Home		1621 Opossumtown Pike, Frederick, MD 21702							
	23e. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) x COLORECTAL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death x 2 yrs							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION DIABETES				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D-31912		29d. Date signed (Month, Day, Year) 6/23/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JULIO MENCAL, MD 1564 OPOSSUMTOWN PIKE / FREDERICK MD 21702												
31. Date filed (Month, Day, Year) JUN 24 1997				32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22076**

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER LARKE SORG

2. Date of Death
Month Day Year
June 19, 1997
3. Time of Death
2:00 AMFuneral
Director

4a. Facility Name (If not institution, give street and number)

7605 Stewart Hill Road

4b. City, Town, or Location of Death

Adamstown

4c. County of Death

Frederick

5. Social Security Number

124-18-8658

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 5, 1926

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Adamstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7605 Stewart Hill Road

10f. Zip Code

21710

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Consult/Entrepreneur

16b. Kind of Business/Industry

Dept. of Commerce

17. Father's Name (First, Middle, Last)

Francis J. Sorg

18. Mother's Name (First, Middle, Maiden Surname)

Emily Brettman

19a. Informant's Name/Relationship (Type, Print)

Bernice R. Sorg/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7605 Stewart Hill Road, Adamstown, Maryland 21710

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Smithsburg Crematory

Date

6/23

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
1201 NORTH MARKET ST., FREDERICK, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Stroke, thrombotic

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Days

b. Cerebral Vascular Disease

Due to (or as a consequence of):

Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

N/A

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0051610

29d. Date signed (Month, Day, Year)

6-20-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1475 Tavey Ave Suite 204 Frederick, MD 21701

31. Date filed (Month, Day, Year)

JUN 23 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22077

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Madeline Elizabeth STONE

2. Date of Death

Month Day Year
June 19, 1997

3. Time of Death

11:30 am

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

215-20-9034

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 23, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4309 Reels Mill Road

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William

C

FLAIR

18. Mother's Name (First, Middle, Maiden Surname)

Marie

E

BRUCHEY

19a. Informant's Name/Relationship (Type, Print)

Barbara L. Anderson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11450 Weller Road, Monrovia, Maryland 21770

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt Olivet Cemetery Jun 23, 1997

Date

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Keith Lynn Robinson M00706

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home

106 E Church Street, Frederick, Maryland 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Congestive Heart Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Years

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension; Insulin-depedent diabetic;

Cerebral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient☒ DOAOther: ☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D16428

29d. Date signed (Month, Day, Year)

June 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper E. Cline III, M.D., 300 West Ninth Street, Frederick, Maryland 21701

State
Registrar

31. Date filed (Month, Day, Year)

JUN 23 1997

32. Registrar's Signature

Casper E. Cline III

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Certificate of Death

Reg. No.

97-22078

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Patrick George Schmidt		2. Date of Death Month Day Year JUNE 18, 1997		3. Time of Death 3:24 AM	
4e. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL I.C.U		4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON	
5. Social Security Number 133-42-0601		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.	
8. Date of Birth (Month, Day, Year) Dec. 14, 1948		9. Birthplace (State or Foreign Country) New York			
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number A22 Ivy Way IB		10f. Zip Code 21702	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Speech Therapist		16b. Kind of Business/Industry Education		17. Father's Name (First, Middle, Last) George William Schmidt	
18. Mother's Name (First, Middle, Maiden Surname) Barbara Ann Tigh		19e. Informant's Name/Relationship (Type, Print) George William Schmidt, father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Foxcroft Ave., 1C, Martinsburg, WV 25401	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Location - City or Town, State Hagerstown, Maryland	
21. Signature of Funeral Service Licensee Ryan M. Bey		22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Cellulitis Due to (or as a consequence of): Morbid Obesity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death weeks 75 Yrs	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24e. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Attysh & Mack, MD		29c. License number O.C.M.E	
29d. Date signed (Month, Day, Year) JUNE 18, 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUN 20 1997	
32. Registrar's Signature John A. Randolph					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22079

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Michael Scott

2. Date of Death

June 17, 1997

3. Time of Death

12:50 AM

4a. Facility Name (If not institution, give street and number)

College View Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

215-58-8813

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 15, 1952

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Clarksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24933 Burnt Hill Road

10f. Zip Code

20871

10g. Citizen of What Country?

American

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Home Remodeling

17. Father's Name (First, Middle, Last)

Richard Martin Scott

18. Mother's Name (First, Middle, Maiden Surname)

Flora Fonneman

19a. Informant's Name/Relationship (Type, Print)

Jacquelyn C. Scott - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24933 Burnt Hill Road, Clarksburg, Maryland 20871

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Clarksburg Methodist

Date

6/19/97

20c. Location - City or Town, State

Clarksburg, Maryland

21. Signature of Funeral Service Licensee

Robert L. Williams

22. Name and Address of Facility

Olin L. Molesworth, P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland 20872-0117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Hepatic Encephalopathy

Due to (or as a consequence of):

b. Alcoholism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Month

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Saeed A. Zaidi

29c. License number

D43091

29d. Date signed (Month, Day, Year)

June 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saeed A. Zaidi, M.D. 801 Toll House Avenue, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 18 1997

Saeed A. Zaidi

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22080

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Calvin McClean Staub				2. Date of Death Month June Day 16 Year 1997		3. Time of Death 5:25 P.M.	
4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
5. Social Security Number 217-28-5789		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) May 12, 1932	
9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent					
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 8556 Indian Springs Rd.				10f. Zip Code 21702		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 52-55		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Realtor		16b. Kind of Business/Industry Own Real Estate Co.	
17. Father's Name (First, Middle, Last) Ernest W. Staub				18. Mother's Name (First, Middle, Maiden Surname) Vida L. Davis			
19a. Informant's Name/Relationship (Type, Print) Kitty Staub / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8556 Indian Springs Rd. / Frederick, Md. 21702			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Tabor Cemetery		20c. Location - City or Town, State 6-20-97 Rocky Ridge, Maryland		21. Signature of Funeral Service Licensee Stauffer Funeral Home	
22. Name and Address of Facility 104 E. Main St. / Thurmont, Maryland		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC POORLY DIFFERENTIATED NON-SMALL CELL LUNG CANCER		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Approximate Interval Between Onset and Death 8 WEEKS	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Bryan M. O'Connor, MD		29c. License number D 31761		29d. Date signed (Month, Day, Year) 6/17/97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bryan M. O'Connor MD 501 W. SEVENTH ST., FREDERICK, MD 21701	
31. Date filed (Month, Day, Year) JUN 19 1997		32. Registrar's Signature Judi Anderson-Randall					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22081

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carroll Ernest Springer				2. Date of Death Month June Day 13 Year 1997		3. Time of Death 3:42 P.M.																		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick																		
Funeral Director	5. Social Security Number 220-16-2927		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) April 17, 1924																		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont																		
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 8213 Rocky Ridge Road		10f. Zip Code 21788		10g. Citizen of What Country? United States																		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Labor		16b. Kind of Business/Industry Farming																				
	17. Father's Name (First, Middle, Last) William Springer				18. Mother's Name (First, Middle, Maiden Surname) Minerva Wilhide																				
	19a. Informant's Name/Relationship (Type, Print) Raymond G. Springer, brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8213 Rocky Ridge Road Thurmont, Maryland 21788																				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Weller United Methodist		Date 6/17/97		20c. Location - City or Town, State Thurmont, Maryland																		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 East Main Street Thurmont, Maryland 21788																						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Cardiomyopathy</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death unknown</td> </tr> <tr> <td>b.</td> <td>Coronary Artery Disease</td> <td>Due to (or as a consequence of):</td> <td>unknown</td> </tr> <tr> <td>c.</td> <td>Ventricular Tachycardia</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Cardiomyopathy	Due to (or as a consequence of):	Approximate Interval Between Onset and Death unknown	b.	Coronary Artery Disease	Due to (or as a consequence of):	unknown	c.	Ventricular Tachycardia	Due to (or as a consequence of):		d.			
	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Cardiomyopathy	Due to (or as a consequence of):	Approximate Interval Between Onset and Death unknown																				
b.		Coronary Artery Disease	Due to (or as a consequence of):	unknown																					
c.		Ventricular Tachycardia	Due to (or as a consequence of):																						
d.																									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																					
28f. Location (Street and Number or Rural Route Number, City or Town, State)																									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																									
29b. Signature and title of certifier 		29c. License number D36649 MD		29d. Date signed (Month, Day, Year) 6/13/97																					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Edward Riuli, M.D. 310 West Ninth Street Frederick, Maryland 21701																									
31. Date filed (Month, Day, Year) JUN 16 1997		32. Registrar's Signature 																							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22082

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Ellen Schreiber

2. Date of Death

Month
JulyDay
3Year
1997

3. Time of Death

8:07 AM

4a. Facility Name (If not institution, give street and number)

Genesis ElderCare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

212-30-1030

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-15-1908

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

TALBOT COUNTY

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

610 DUTCHMANS LANE

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERICAL

16b. Kind of Business/Industry

OFFICE

17. Father's Name (First, Middle, Last)

GEORGE

LITZ

18. Mother's Name (First, Middle, Maiden Surname)

EDITH

E.

BRUFF

19a. Informant's Name/Relationship (Type, Print)

ANNE MARIE ENGLEHART (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

64 PARK LANE, EASTON, MD. 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

7/7/97

20c. Location - City or Town, State

GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE.

Due to (or as a consequence of):

24 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEPSIS

Due to (or as a consequence of):

3 WEEKS

c. CONGESTIVE HEART FAILURE.

Due to (or as a consequence of):

YEARS

d. CARDIAC ARHYTHMIA.

YEARS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

H48241

7/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID E. MARAS, DO 508 IDLEWILD AVE. EASTON, MD 21601

31. Date filed (Month, Day, Year)

7/31/97

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22083

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John A. Stansbury				2. Date of Death Month Day Year July 8, 1997		3. Time of Death 4:00 P.M.	
	4a. Facility Name (If not institution, give street and number) 1108 Central Ave. East				4b. City, Town, or Location of Death Edgewater		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 578-22-3224		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 7, 1923	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Edgewater	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1108 Central Ave. East		10f. Zip Code 21037		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-Employed		16b. Kind of Business/Industry Plumbing Contractor			
	17. Father's Name (First, Middle, Last) Ducilmer A. Stansbury				18. Mother's Name (First, Middle, Maiden Surname) Blanche Smith			
	19a. Informant's Name/Relationship (Type, Print) Erma E. Stansbury/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1108 Central Ave. East Edgewater, Md. 21037			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 7-11-97		20c. Location - City or Town, State Suitland, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cachexia of malignancy Due to (or as a consequence of): b. gliosarcoma - Brain Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 months 6 months							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number 008314		29d. Date signed (Month, Day, Year) 7/9/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Samaras, M.D. 205 Ridgely Avenue Annapolis, Maryland 21401								
31. Date filed (Month, Day, Year) JUL 10 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22084

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Anthony Swan</i>				2. Date of Death Month <i>7</i> Day <i>-03</i> Year <i>-97</i>				3. Time of Death <i>1820</i>	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number <i>194-16-9936</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>71</i> Yrs.		8. Date of Birth Month <i>Aug</i> Day <i>13</i> Year <i>1925</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>Virginia</i>		10b. County <i>Accomack</i>		10c. City, Town or Location <i>Wallops Island</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <i>8110 Mifflin Road</i>				10f. Zip Code <i>23337</i>		10g. Citizen of What Country? <i>U. S. A.</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WW II</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Diesel Mechanics</i>			16b. Kind of Business/Industry <i>Hall Motor Transport</i>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Anthony Swan</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Ethel Hall</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Joseph A. Swan</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>329 E. Cornwall Street, Philadelphia, Pa. 19134</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Green Mount Cemetery</i>		Date <i>7-9-97</i>		20c. Location - City or Town, State <i>Philadelphia, Pa.</i>			
	21. Signature of Funeral Service Licensee <i>Constantine delon Gordon Bailey</i>				22. Name and Address of Facility <i>Sage Funeral Home Chincoteague, Virginia 23336</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Lung Disease</i>									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown									
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>John G. Bulkeley D.M.E.</i>				29c. License number <i>003599</i>		29d. Date signed (Month, Day, Year) <i>7-3-97</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>John T. Bulkeley, M.D., 108 Pine Bluff Rd., Salisbury, Md.</i>									
	31. Date filed (Month, Day, Year) <i>JUL 07 1997</i>		32. Registrar's Signature <i>John T. Bulkeley</i>							

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..
... ..
... ..

... ..

22085

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician /Medical Examiner: Edward G. Stanley

Funeral Director: To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Edward G. Stanley

2. Date of Death: June 24, 1997

3. Time of Death: 10:55 PM

4a. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

5. Social Security Number: 217-00-2098

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 79 Yrs.

8. Date of Birth (Month, Day, Year): June 7, 1918

9. Birthplace (State or Foreign Country): Maryland

10a. State: md.

10b. County: Wicomico

10c. City, Town or Location: Mardela Springs

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 25728 Coopermill Rd

10f. Zip Code: 21837

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance

16b. Kind of Business/Industry: Dupont Co

17. Father's Name (First, Middle, Last): Harvey Smiley

18. Mother's Name (First, Middle, Maiden Surname): Eliza Smiley

19a. Informant's Name/Relationship (Type, Print): Hortense A Stanley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25728 Coopermill Rd 21837

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify):

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland VA Zood CR

20c. Location - City or Town, State: Mardela md.

21. Signature of Funeral Service Licensee: Ronald Flaherty

22. Name and Address of Facility: Williamson - Flaherty 917 W Isabella St Salisbury

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death): SEPSIS Due to (or as a consequence of): Cerebral Vascular Accident. SEIZURE DISORDER. MULTI INFARCT DEMENTIA. HYPOTHYROIDISM. Approximately Interval Between Onset and Death: 1 WEEK. YEARS.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify):

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year):

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier: [Signature]

29c. License number: H48241

29d. Date signed (Month, Day, Year): 6/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DANIEL E. MAKAS, PO BOX IDEWILD AVE EASTON, MD 21601

31. Date filed (Month, Day, Year): JUL 03 1997

32. Registrar's Signature: Julia Davidson-Randall

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22086

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Elizabeth Tall

2. Date of Death

July 10 1997 11:59am.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

214-30-8775

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 12, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Crocherson

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1511 Crocherson Road

10f. Zip Code

21672

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Seafood Worker

16b. Kind of Business/Industry

Seafood Plant

17. Father's Name (First, Middle, Last)

Robert W. Bloodsworth

18. Mother's Name (First, Middle, Maiden Surname)

Eva Adelle Todd

19a. Informant's Name/Relationship (Type, Print)

Beverly J. Todd Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1513 Crocherson Road Bishops Head, Maryland 21672

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dorchester Memorial Park 7/13/97 Cambridge, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.

700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 min

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

D26388

29d. Date signed (Month, Day, Year)

07-10-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Fadden M.D. 408 Byrn St. Cambridge MD 21613

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 908.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

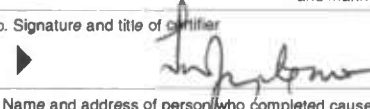

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22087

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY M. TWIGG				2. Date of Death Month JULY Day 6 Year 1997		3. Time of Death 5:43 A.M.		
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 212-24-1145		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) JUL 29, 1907		
	10e. State MD		10b. County Allegany		10c. City, Town or Location Cumberland		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 115 East Mary Street				10f. Zip Code 21502		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Practical Home Nurse		16b. Kind of Business/Industry Nursing				
	17. Father's Name (First, Middle, Last) Charles William Turner				18. Mother's Name (First, Middle, Maiden Surname) Katherine M. (Smith)				
	19a. Informant's Name/Relationship (Type, Print) Matt Cline-grandson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 846 Mt. Royal Avenue Cumberland MD 21502				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park		Date 07/08		20c. Location - City or Town, State Cumberland MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Scarpelli Funeral Home Cumberland MD 21502				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate interval Between Onset and Death One Week	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyponatremia							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 33280		29d. Date signed (Month, Day, Year) July 7, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil Gupta M.D. Johnson Heights Cumberland, MD 21502									
31. Date filed (Month, Day, Year) JUL 08 1997		32. Registrar's Signature 							

Amended Line 18 Felt

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22088**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Norman Ellwood Toms, Jr.				2. Date of Death Month June Day 29 Year 1997		3. Time of Death 3:25 PM		
	4a. Facility Name (If not Institution, give street and number) 12907 Brice Road				4b. City, Town, or Location of Death Thurmont		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 216-22-7538		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 20, 1927	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 12907 Brice Road				10f. Zip Code 21788		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) -		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Press Foreman		16b. Kind of Business/Industry Moore Business Forms				
	17. Father's Name (First, Middle, Last) Norman Ellwood Toms, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Catherine Toms Helene Belle				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Pamela Wivell / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12907 Brice Road, Thurmont, Maryland 21788				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Garden		Date 7/3/97		20c. Location - City or Town, State Frederick, Maryland		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Stauffer Funeral Home 104 E. Main Street, Thurmont, MD 21788				
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC ADENOCARCINOMA OF PROSTATE								
	Approximate Interval Between Onset and Death 5 YEARS								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 031761		29d. Date signed (Month, Day, Year) 6/30/97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN M. O'CONNOR, MD 501 W. SEVENTH ST., FREDERICK, MD 21701									
31. Date filed (Month, Day, Year) JUL 02 1997		32. Registrar's Signature <i>[Signature]</i>							

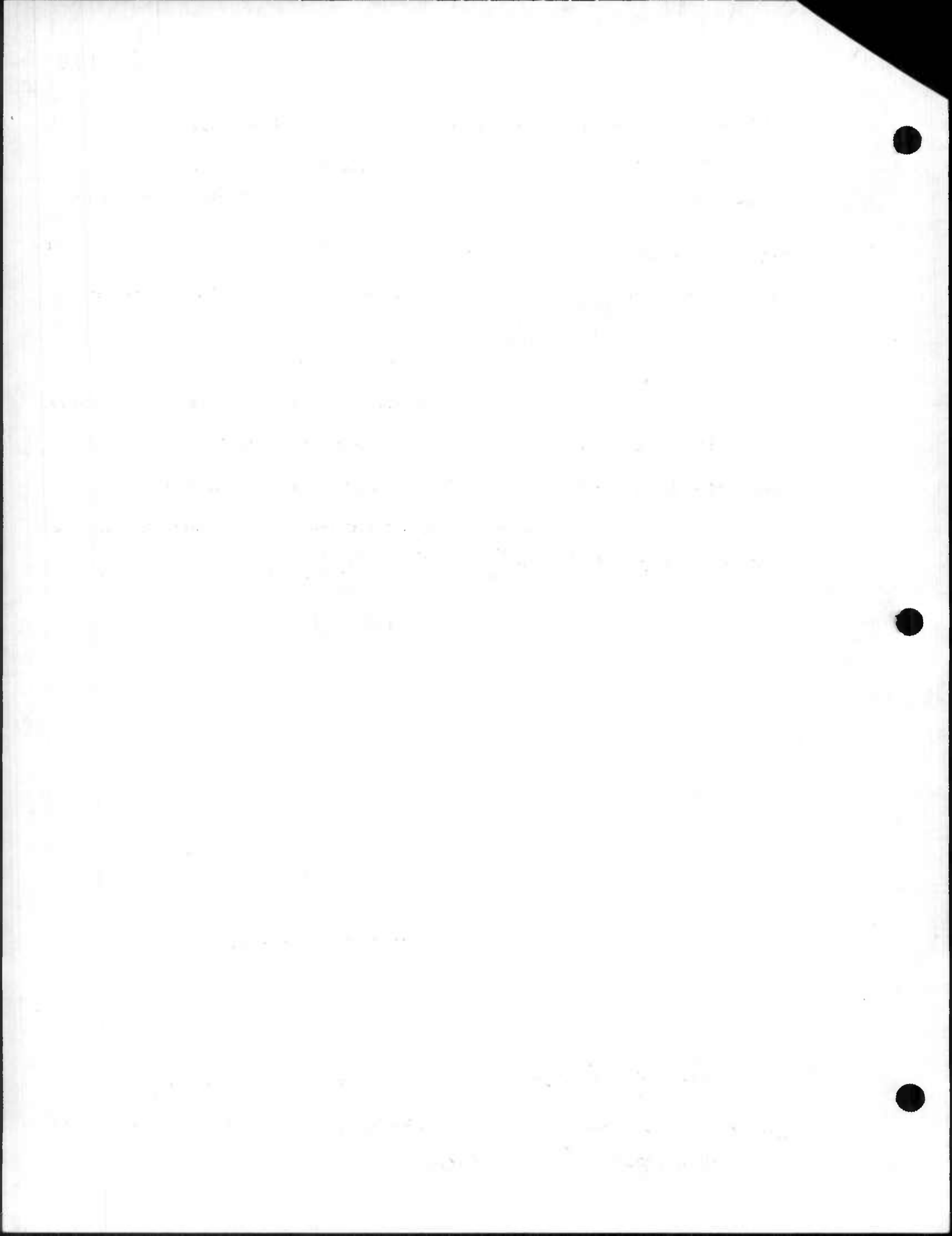
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22089

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Ralph Milton TIPLING III

2. Date of Death

Month Day Year
June 21, 1997

3. Time of Death

2400 hrs

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

526-06-2445

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 19, 1952

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

123 East 8th Street

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Production/Repair

17. Father's Name (First, Middle, Last)

Ralph Milton

TIPLING II

18. Mother's Name (First, Middle, Maiden Surname)

Lois Jean MILLER

19a. Informant's Name/Relationship (Type, Print)

Vickie Lynn Tipling/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

123 East 8th Street, Frederick, Maryland 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory Jun 26, 1997

Date

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Kathy Lynn Robinson M00706

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home
106 East Church St., Frederick, Maryland 21701

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Amyotrophic Lateral Sclerosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

Stephen Lee M.D.

29c. License number

D42641

29d. Date signed (Month, Day, Year)

June 22, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen Lee, M.D., 56 Thomas Johnson Drive, Frederick, Maryland 21702

31. Date filed (Month, Day, Year)

JUN 24 1997

32. Registrar's Signature

Stephen Lee

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

2000

Handwritten signature or text, possibly "Handwritten signature"

Handwritten signature or text, possibly "Handwritten signature"

Handwritten text, possibly "Handwritten text"

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROOSEVELT THOMAS				2. DATE OF DEATH MONTH DAY YEAR JULY 6 1997		3. TIME OF DEATH 5:20 am M	
4. SOCIAL SECURITY NUMBER 262-28-7275		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 18 1924	
8. BIRTHPLACE (State or Foreign Country) FLORIDIA				9a. FACILITY NAME (If not institution, give street and number) ANNAPOLIS NURSING & REHAB. CENTER		9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION ANNAPOLIS				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1813 COPELAND STREET	
10f. ZIP CODE 21401				10g. CITIZEN OF WHAT COUNTRY? US		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTODIAN		16b. KIND OF BUSINESS/INDUSTRY CAPITAL THEATER	
17. FATHER'S NAME (First, Middle, Last) LAWRENCE THOMAS				18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN- Viola Wilson			
19a. INFORMANT'S NAME (Type/Print) SYLVIA THOMAS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 COPELAND STREET ANNAPOLIS, MD. 21401			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERAN CEMETERY 7/10/97		20c. LOCATION — City or Town, State CROWNSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Stroke</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>Brief many years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Insulin Dependent Diabetes Mellitus</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. L. Hochman, MD</i>		29c. LICENSE NUMBER D05192	
29d. DATE SIGNED (Month, Day, Year) 7/6/97				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard I. Hochman, MD 1833A Forest Dr., Annapolis, Md - 21401			
31. DATE FILED (Month, Day, Year) JUL 08 1997				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

000000

X
A. L. Hock
Richard I. Hockman
JUL 08 1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22091

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Louise Pearl Thomas</i>						2. Date of Death Month <i>June</i> Day <i>15</i> Year <i>97</i>		3. Time of Death <i>12:45 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>25945 Quinton Rd</i>						4b. City, Town, or Location of Death <i>Mardela Springs</i>		4c. County of Death <i>Wicomico</i>	
Funeral Director	5. Social Security Number <i>219-07-7037</i>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>76</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>April 25, 1921</i>		9. Birthplace (State or Foreign Country) <i>DELAWARE</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>md.</i>		10b. County <i>Wicomico</i>		10c. City, Town or Location <i>Mardela Springs</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <i>25945 Quinton Rd.</i>				10f. Zip Code <i>21837</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>2</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Providing Nursing</i>				16b. Kind of Business/Industry <i>Nursing</i>			
	17. Father's Name (First, Middle, Last) <i>Charles Ellis</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Betha Ellis</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Norman Thomas Husband</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>25945 Quinton Rd Mardela Springs md. 21837</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Spring Hill Cemetery</i>		20c. Location - City or Town, State <i>6/1/97 Habersham md.</i>					
	21. Signature of Funeral Service Licensee <i>Shirley M. Fidelity</i>						22. Name and Address of Facility <i>Williamson - Flaherty 7/5 Pa 917 W Isabella St Salisbury md.</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.									
	<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>advanced lung cancer and pancreatic cancer</i> Due to (or as a consequence of):</p> <p>b. <i>dehydration and weight loss</i> Due to (or as a consequence of):</p> <p>c. <i>hypoperfusion & hypoxia due to</i> Due to (or as a consequence of):</p> <p>d. <i>circulatory failure</i></p>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Peptic ulcer disease</i> <i>irregular heart beat</i>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Khalil Gorgui M.D.</i>		29c. License number <i>CI-000 4569</i>		29d. Date signed (Month, Day, Year) <i>06/25/97</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>KHALIL GORGUI, 8 E. GROVE ST. DELMAR, DE 19940</i>										
31. Date filed (Month, Day, Year) <i>JUL 03 1997</i>		32. Registrar's Signature <i>John Davidson-Randall</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

97-3696-035

ML

DONALD E. WILSON

Items: 23a part I, 27, 28a-f per MEO G-749 7/23/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22092

Physician
/Medical
Examiner

Donald E. Wilson

2. Date of Death
Month Day Year
JULY 04 1997
3. Time of Death
10:15 AM

4a. Facility Name (If not institution, give street and number)

218 DOMINION ROAD

4b. City, Town, or Location of Death

CHESTER

4c. County of Death

QUEEN ANNES

Funeral
Director

5. Social Security Number

217 68 7883

6. Sex

M 2 F

7. Age (In yrs. last birthday)

39

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 18, 1957

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Capital Heights

10d. Inside City Limits

1 Yes 2 No
xx

10e. Street and Number

7001 Giddings Drive

10f. Zip Code

20703

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: 1976

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

1 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Alfred E. Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Doris King

19a. Informant's Name/Relationship (Type, Print)

Doris Wilson Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7001 Giddings Drive Capital Heights Md. 20703

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

July 10, 1997

20c. Location - City or Town, State

Crownsville Maryland

21. Signature of Funeral Service Licensee

Michael L. Sigler

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METHANOL INTOXICATION

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

7/4/97

28b. Time of Injury

unknown

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

subject ingested methanol

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

218 Dominion Road, Chester, Queen Anne's County, Maryland

29a. Certifier (Check only one)

1 Certifying Physician

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael L. Sigler

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 05, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ann Dixon

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 2 2 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22093

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANK M. WRIGHT

2. Date of Death

Month

Day

Year

3. Time of Death

09:59 AM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

306 14 8118

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept 15, 1916

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6409 Wilburn Drive

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 41-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Analyst

16b. Kind of Business/Industry

Social Security Admin

17. Father's Name (First, Middle, Last)

Charles Wright

18. Mother's Name (First, Middle, Maiden Surname)

Orpha Jackson

19a. Informant's Name/Relationship (Type, Print)

Lydia A. Wright

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6409 Wilburn Drive, Capitol Heights, MD 20743

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lee Crematory July 8, 1997

Date

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Lee Funeral Home, Inc 6633
Old Alexandria Ferry Rd, Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

PME

29c. License number

D33954

29d. Date signed (Month, Day, Year)

JULY 07, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARCO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY MARYLAND 20785

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

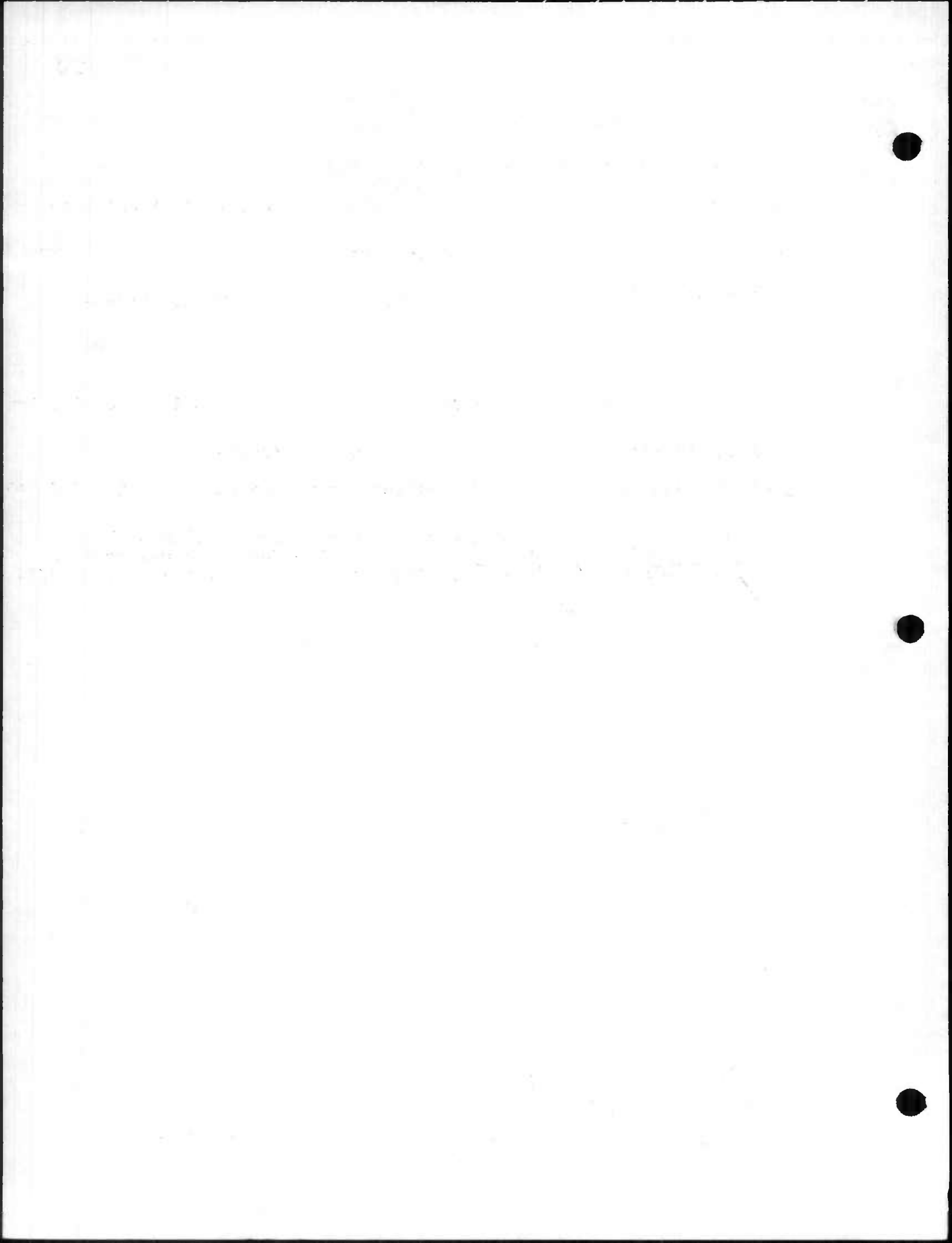
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22094**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nance Williams				2. Date of Death Month June Day 29 Year 1997		3. Time of Death 10:40A.M.	
	4a. Facility Name (If not institution, give street and number) Deer's Head Center				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 217-34-1694		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location SALISBURY		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 351 DEER'S HEAD HOSPITAL DRIVE				10f. Zip Code 21802		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry AGRICULTURE		
17. Father's Name (First, Middle, Last) MOSELEY WILLIAMS				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN				
19a. Informant's Name/Relationship (Type, Print) DIANE P. HUGHES/SOCIAL WORKER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. BOX 2018, SALISBURY, MARYLAND 21802				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) JERUSALEM CEMETERY		Date 7/3/97		20c. Location - City or Town, State PARSONSBURG, MARYLAND		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ZELLER FUNERAL HOME, P. O. BOX 3171, 1110 OLD OCEAN CITY ROAD, SALISBURY, MD 21802				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. Cerebral Vascular Accident With Seizures					Approximate Interval Between Onset and Death 16 days	
		Due to (or as a consequence of):						
		b. Recurrent Cerebral Vascular Accident					32 years	
		Due to (or as a consequence of):						
		c. Oranic Brain Syndrome					1965 death	
		Due to (or as a consequence of):						
		d. Alcoholism					years before 1965	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
		29c. License number D33905		29d. Date signed (Month, Day, Year) 6/29/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V.A. Dulany, M.D., CMD; P.O. Box 2018; Salisbury, Md. 21802								
31. Date filed (Month, Day, Year) JUL 9 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22095

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RAY GILBERT WEAVER

2. Date of Death

July 2 1997

3. Time of Death

6:30a.m.

4e. Facility Name (If not institution, give street and number)

8813 Jordan Road

4b. City, Town, or Location of Death

Fairplay

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

219-14-7854

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 16, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Fairplay

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8785 Jordan Road

10f. Zip Code

21733

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cattle Breeder

16b. Kind of Business/Industry

Cattle Producing Co.

17. Father's Name (First, Middle, Last)

George Edward Weaver

18. Mother's Name (First, Middle, Maiden Surname)

Mary Edith Cline

19a. Informant's Name/Relationship (Type, Print)

Douglas E. Weaver, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8813 Jordan Road, Fairplay, Maryland 21733

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

July 3

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

► Kelly A. Younger

22. Name and Address of Facility

Douglas A. Fiery Funeral Home
1331 Eastern Blvd. N., Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Severe aortic stenosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease
Restrictive Lung Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Jimmy MD

29c. License number

D41827

29d. Date signed (Month, Day, Year)

7/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Alenberry MD, 12821 Oak Hill Ave, Hagerstown MD 21740

31. Date filed (Month, Day, Year)

JUL 7 1997

32. Registrar's Signature

► Julia Davidson-Randall

MD 21740

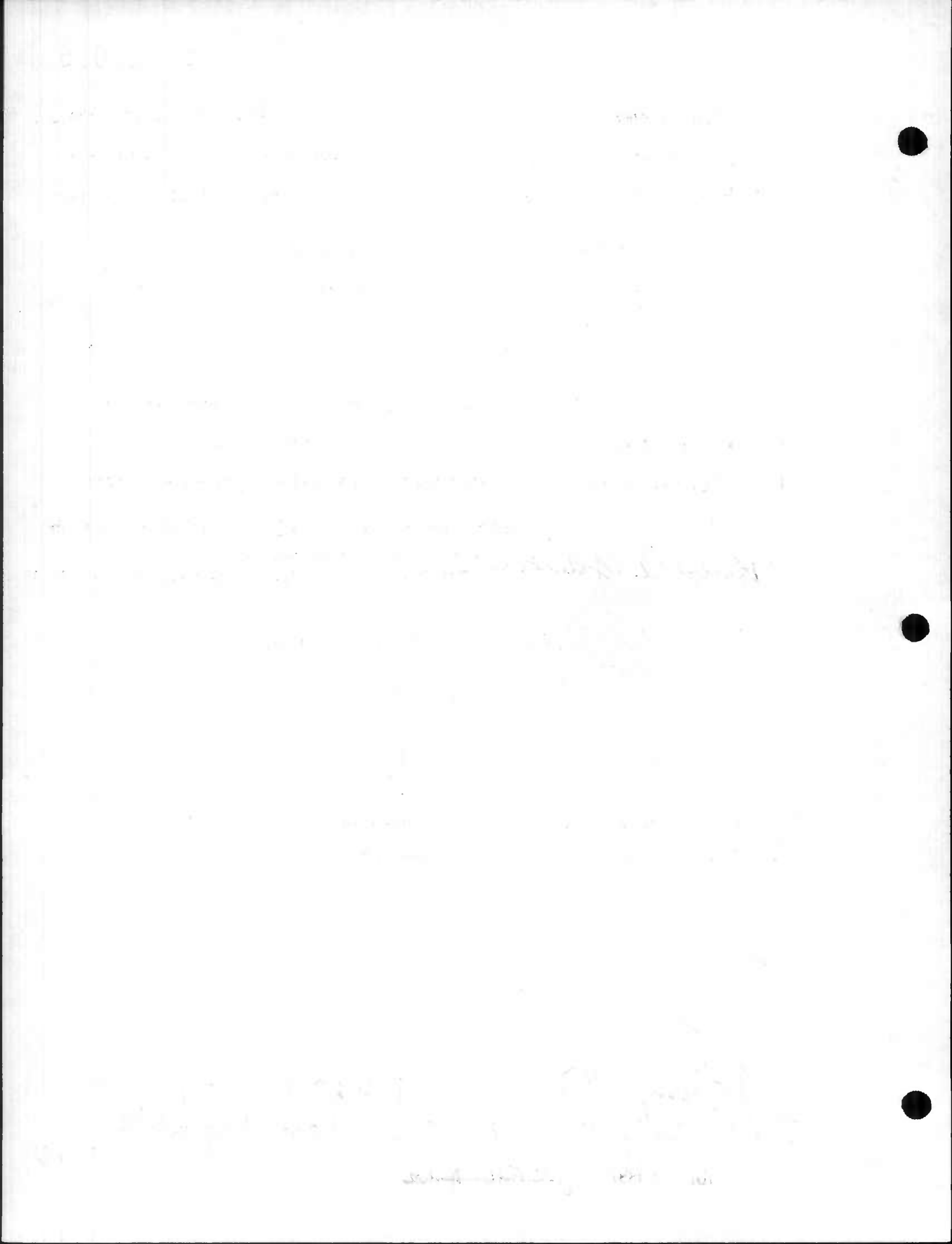
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

97 22096

Amed # 109 WASH CO. 813 July 3, 1997 Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Floyd William Weiser

2. Date of Death

Month
JulyDay
1Year
1997

3. Time of Death

8:12 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

251 E. Antietam

St.

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

213-42-2071

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Sept. 17-43

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7 E. Washington St.

10f. Zip Code

21740

10g. Citizen of What Country?

Washington, USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1962-65

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tool Crib

16b. Kind of Business/Industry

Army Depot

17. Father's Name (First, Middle, Last)

Woodrow W. Younker

18. Mother's Name (First, Middle, Maiden Surname)

Nellie B. Dishong

19a. Informant's Name/Relationship (Type, Print)

Allen M. Weiser /Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 424 State Line, Pa. 17263

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

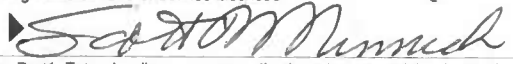
Date

7/5/97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple trauma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

SUDDEN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

July 1, 1997 7:43 AM

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

jumped out 4th floor window

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7 E. Washington St. Hag, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D11266

29d. Date signed (Month, Day, Year)

July 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

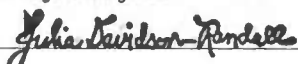
Howard N. Weeks, M.D. 580 Northern Ave. Hagerstown, MD 21742

State
Registrar

31. Date filed (Month, Day, Year)

JUL 3 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22097**
Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. Decedent's Name (First, Middle, Last) Richard F Welton, III				2. Date of Death Month Day Year June 29 1997		3. Time of Death 1635	
4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
5. Social Security Number 231-01-5645		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Jan 12, 1919	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 5 Byford Court		10f. Zip Code 21620		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retail Executive		16b. Kind of Business/Industry Retail			
17. Father's Name (First, Middle, Last) Richard F. Welton Jr.				18. Mother's Name (First, Middle, Maiden Surname) Alice Boardman			
19a. Informant's Name/Relationship (Type, Print) Elizabeth Beck Welton				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Byford Court Chestertown, Md. 21620			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Pauls Church Cemetery		20c. Location - City or Town, State 7/2/97 Chestertown, MD		20d. Date	
21. Signature of Funeral Service Licensee Seymour				22. Name and Address of Facility Fellows, Helfenbein, Newnam Funeral Home 130 Speer Road Chestertown, md. 21620 410-778-0055			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)		a. CONGESTIVE HEART FAILURE				Approximate Interval Between Onset and Death 1 yr	
		b. ISCHEMIC CORONARY ARTERY DISEASE				6 mos	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		c.					
		d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J. Seymour M.D.		29c. License number A-13824		29d. Date signed (Month, Day, Year) 7-9-97	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Seymour, M.D., 122 Speer Road, Chestertown, Maryland 21620							
31. Date filed (Month, Day, Year) JUN 10 '97		32. Registrar's Signature Phia Davidson-Randall					

1995-1996

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

2033

2034

2035

2036

2037

2038

2039

2040

2041

2042

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2054

2055

2056

2057

2058

2059

2060

2061

2062

2063

2064

2065

2066

2067

2068

2069

2070

2071

2072

2073

2074

2075

2076

2077

2078

2079

2080

2081

2082

2083

2084

2085

2086

2087

2088

2089

2090

2091

2092

2093

2094

2095

2096

2097

2098

2099

2100

2101

2102

2103

2104

2105

2106

2107

2108

2109

2110

2111

2112

2113

2114

2115

2116

2117

2118

2119

2120

2121

2122

2123

2124

2125

2126

2127

2128

2129

2130

2131

2132

2133

2134

2135

2136

2137

2138

2139

2140

2141

2142

2143

2144

2145

2146

2147

2148

2149

2150

2151

2152

2153

2154

2155

2156

2157

2158

2159

2160

2161

2162

2163

2164

2165

2166

2167

2168

2169

2170

2171

2172

2173

2174

2175

2176

2177

2178

2179

2180

2181

2182

2183

2184

2185

2186

2187

2188

2189

2190

2191

2192

2193

2194

2195

2196

2197

2198

2199

2200

2201

2202

2203

2204

2205

2206

2207

2208

2209

2210

2211

2212

2213

2214

2215

2216

2217

2218

2219

2220

2221

2222

2223

2224

2225

2226

2227

2228

2229

2230

2231

2232

2233

2234

2235

2236

2237

2238

2239

2240

2241

2242

2243

2244

2245

2246

2247

2248

2249

2250

2251

2252

2253

2254

2255

2256

2257

2258

2259

2260

2261

2262

2263

2264

2265

2266

2267

2268

2269

2270

2271

2272

2273

2274

2275

2276

2277

2278

2279

2280

2281

2282

2283

2284

2285

2286

2287

2288

2289

2290

2291

2292

2293

2294

2295

2296

2297

2298

2299

2300

2301

2302

2303

2304

2305

2306

2307

2308

2309

2310

2311

2312

2313

2314

2315

2316

2317

2318

2319

2320

2321

2322

2323

2324

2325

2326

2327

<

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEWIS GARFIELD WILSON						2. Date of Death Month Day Year JULY 03, 1997		3. Time of Death 2230PM						
	4a. Facility Name (If not Institution, give street and number) ROUTE 300 AND ROUTE 290						4b. City, Town, or Location of Death SUDLERSVILLE		4c. County of Death QUEEN ANNES						
Funeral Director	5. Social Security Number 213-24-4978		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) September 29, 1922 Maryland		9. Birthplace (State or Foreign Country)						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Millington				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	10e. Street and Number 30840 River Road				10f. Zip Code 21651		10g. Citizen of What Country? U.S.A.								
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver/Heavy Equipment Operator Escavating			16b. Kind of Business/Industry							
	17. Father's Name (First, Middle, Last) Warren Taylor						18. Mother's Name (First, Middle, Maiden Surname) Emma Wilson								
	19a. Informant's Name/Relationship (Type, Print) Elizabeth A. Wilson/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30840 River Road, Millington, Maryland 21651										
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Asbury Cemetery Chestertown Forest Millington, Maryland				20c. Location - City or Town, State July 12, 1997		20d. Location - City or Town, State						
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 7-3-97		28b. Time of Injury 2120 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred DRIVER, AUTO STRUCK ANOTHER AUTO							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt 300 and Rt 290 Queen Anne's County													
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier Donald G. Wright MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 04, 1997	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201										31. Date filed (Month, Day, Year) JUN 10 '97		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22099

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Basil Brook WHETZEL, SR.

2. Date of Death

Month Day Year
July 3, 1997

3. Time of Death

3:45 A.M.

4a. Facility Name (If not institution, give street and number)

Frederick Health Care Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

225-09-9273

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 15, 1916

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Knoxville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2606 Kaetzl Road

10f. Zip Code

21758

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates: 1942-194513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Maintenance Worker

16b. Kind of Business/Industry

Shoe Factory

17. Father's Name (First, Middle, Last)

Harvey Rufus WHETZEL

18. Mother's Name (First, Middle, Maiden Surname)

Lulu May DOVE

19a. Informant's Name/Relationship (Type, Print)

Thelma V. Cutsail, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6207 Quinn Road, Frederick, MD 21701

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resthaven Mem. Gardens, July 6, 1997 Frederick, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

Allan H Ruby MO0703

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home
106 East Church Street, Frederick, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause of death.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

Kathleen W Stern MD

29c. License number

D32073

29d. Date signed (Month, Day, Year)

July 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Kathleen W. Stern, M.D., 610 Ninth Avenue, Brunswick, MD 21716

State
Registrar

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

Kathleen Randall

Baltimore, Maryland 21215-0020

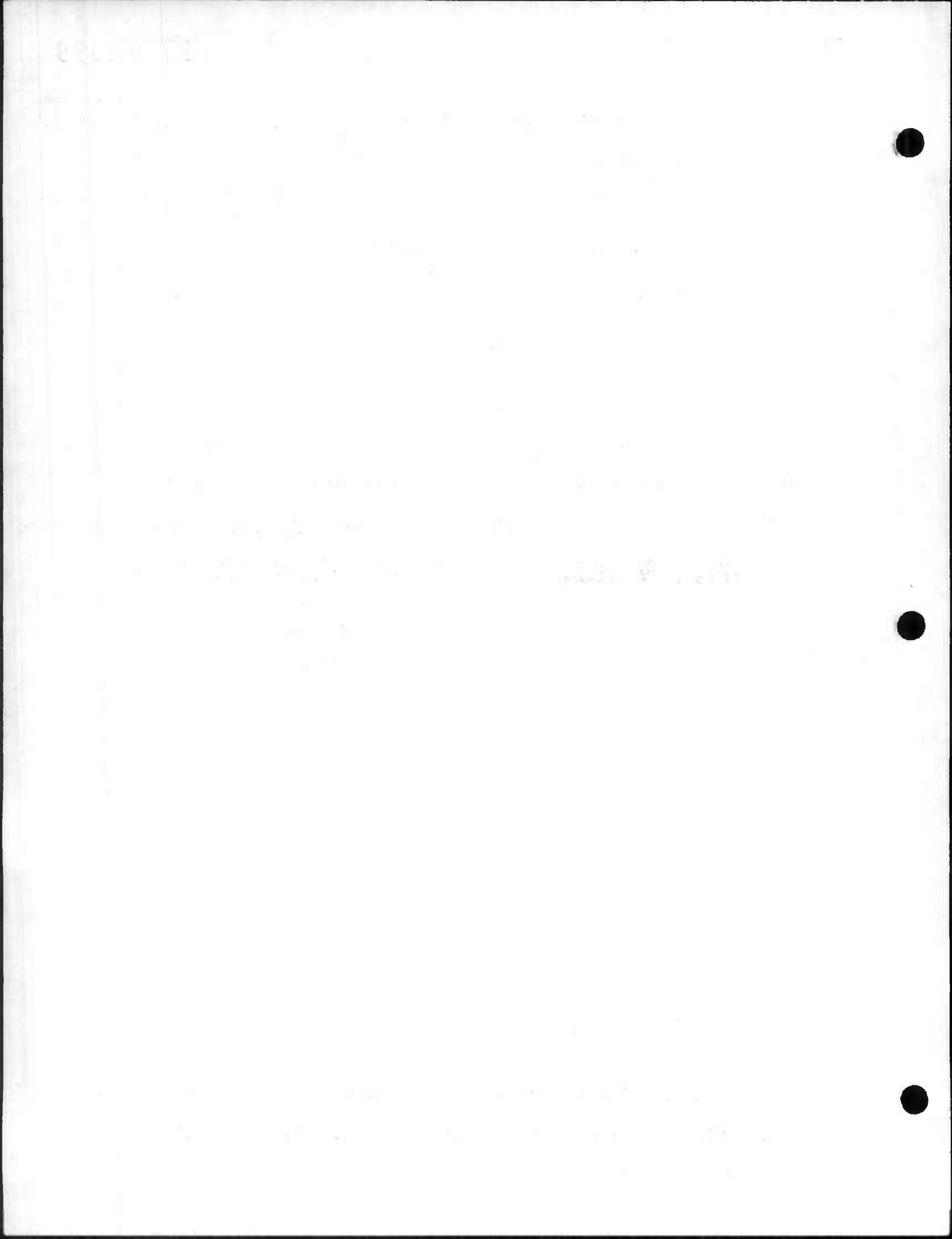
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

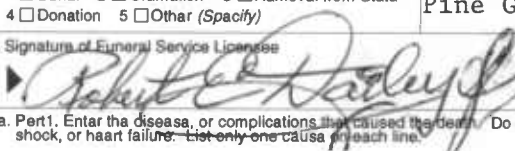


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22100

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GOLDIE CHANDLEE WEAVER				2. Date of Death Month: June Day: 26 Year: 1997		3. Time of Death 8:00 AM	
	4a. Facility Name (If not institution, give street and number) 910 Pontiac Avenue				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-34-2253		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) May 18, 1902	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 910 Pontiac Avenue		10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Her home			
	17. Father's Name (First, Middle, Last) Veazey Chandlee				18. Mother's Name (First, Middle, Maiden Surname) Jane Ann Stokes			
	19a. Informant's Name/Relationship (Type, Print) Barbara J. Batdorf/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7916 Long Meadow Drive, Frederick, MD 21701			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery		20c. Date 6/30		20d. Location - City or Town, State Sunnyburn, PA	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701			
	23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Cerebrovascular accident				23b. Do not enter the mode of dying, such as cardiac or respiratory arrest. 1989			
	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension				23d. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number DD9689		29d. Date signed (Month, Day, Year) 6/27/97	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) A. Austin Pearre Jr., MD 300 West Ninth Street, Frederick, Maryland 21701							
	31. Date filed (Month, Day, Year) JUN 27 1997		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

1000000000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22101**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Berry Thurman Wright Jr.				2. Date of Death Month June Day 23 Year 1997		3. Time of Death 1:45 PM	
	4a. Facility Name (If not institution, give street and number) Vindabona Nursing Home				4b. City, Town, or Location of Death Braddock Hgts.		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 579-28-2706		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 15, 1924	
	10e. State Md.		10b. County Frederick		10c. City, Town or Location Jefferson		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 5621 Glen Hill Ct.				10f. Zip Code 21755		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) offset printer		16b. Kind of Business/Industry research corp.	
	17. Father's Name (First, Middle, Last) Berry Thurman Wright Sr.				18. Mother's Name (First, Middle, Maiden Surname) Catherine France			
	19a. Informant's Name/Relationship (Type, Print) Robin Wright (Daughter-in-law)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5621 Glen Hill Ct., Jefferson, Md. 21755			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Monacacy Cemetery		20c. Date 6/26		20d. Location - City or Town, State Beallsville, Md.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. congestive heart failure Due to (or as a consequence of): b. presumed myocardial infarction Due to (or as a consequence of): c. atherosclerotic coronary artery disease Due to (or as a consequence of): d. colon carcinoma Approximate interval Between Onset and Death a. ~ 1 day b. long c. stage							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic active Hepatitis C Cirrhosis, Cachexia Anemia							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury NA M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NA		28d. Describe how Injury occurred NA					
	28f. Location (Street and Number or Rural Route Number, City or Town, State) NA		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier 				29c. License number D47169		29d. Date signed (Month, Day, Year) 6/25/97	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR CHANG HING HO 600 9TH AVE. BRUNSWICK MD. 21716							
	31. Date filed (Month, Day, Year) JUN 28 1997				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22102

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGUERITE EYLER WILHIDE

2. Date of Death

Month Day Year
June 19, 1997

3. Time of Death

1:25 AM

4a. Facility Name (If not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

220-03-3909

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 27, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number Citizens Nursing Home

Rosemont Avenue

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Hairstylist

16b. Kind of Business/Industry

Not Known

17. Father's Name (First, Middle, Last)

Everst C. Eyer

18. Mother's Name (First, Middle, Maiden Surname)

Edna Blanche Carty

19a. Informant's Name/Relationship (Type, Print)

Robert W. Wilhide, Sr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7128 Blue Mountain Road, Thurmont, MD 21788

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Blue Ridge Cemetery

Date

6/21

20c. Location - City or Town, State

Thurmont, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
615 EAST MAIN ST., THURMONT, MD 2178823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause of death.Immediate Cause (Final
disease or condition
resulting in death)e. Chronic Obstructive Pulmonary Disease years
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Heart Disease
Breast Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D16428

29d. Date signed (Month, Day, Year)

6/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CASPER E. CLINE, III, MD 300 West 9th Street Frederick, Md. 21701

31. Date filed (Month, Day, Year)

JUN 23 1997

32. Registrar's Signature

Casper E. Cline, III

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

501

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22103

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

STERLING JOHN WETZEL JR.

2. Date of Death

Month Day Year
JUNE 17, 1997

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director5. Social Security Number
217-32-60776. Sex
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)
61 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
April 18, 19369. Birthplace (State or Foreign
Country)
Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Union Bridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10321 Bessie Clemons Road

10f. Zip Code

21791

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give Year or Date 1954-195713. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer/ Equipment Operator

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Sterling John WETZEL SR.

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Louise BAGENT

19a. Informant's Name/Relationship (Type, Print)

Mrs. Helen Wetzel, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10321 Bessie Clemons Road, Union Bridge, Md. 21791

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Smithsburg Crematory

Date

June 20, 1997

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Richard E. Graf

MO0255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home

106 East Church Street, Frederick, Md. 21701

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Congestive Heart Failure
Due to (or as a consequence of):b. Ischemic Cardiomyopathy
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

6 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MITRAL Regurgitation

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation 6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John A. Vitarello MD

29c. License number

D27544

29d. Date signed (Month, Day, Year)

June 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. John A. Vitarello, MD 310 West Ninth Street, Frederick, Md. 21701

31. Date filed (Month, Day, Year)

JUN 18 1997

32. Registrar's Signature

John A. Vitarello

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
9059.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

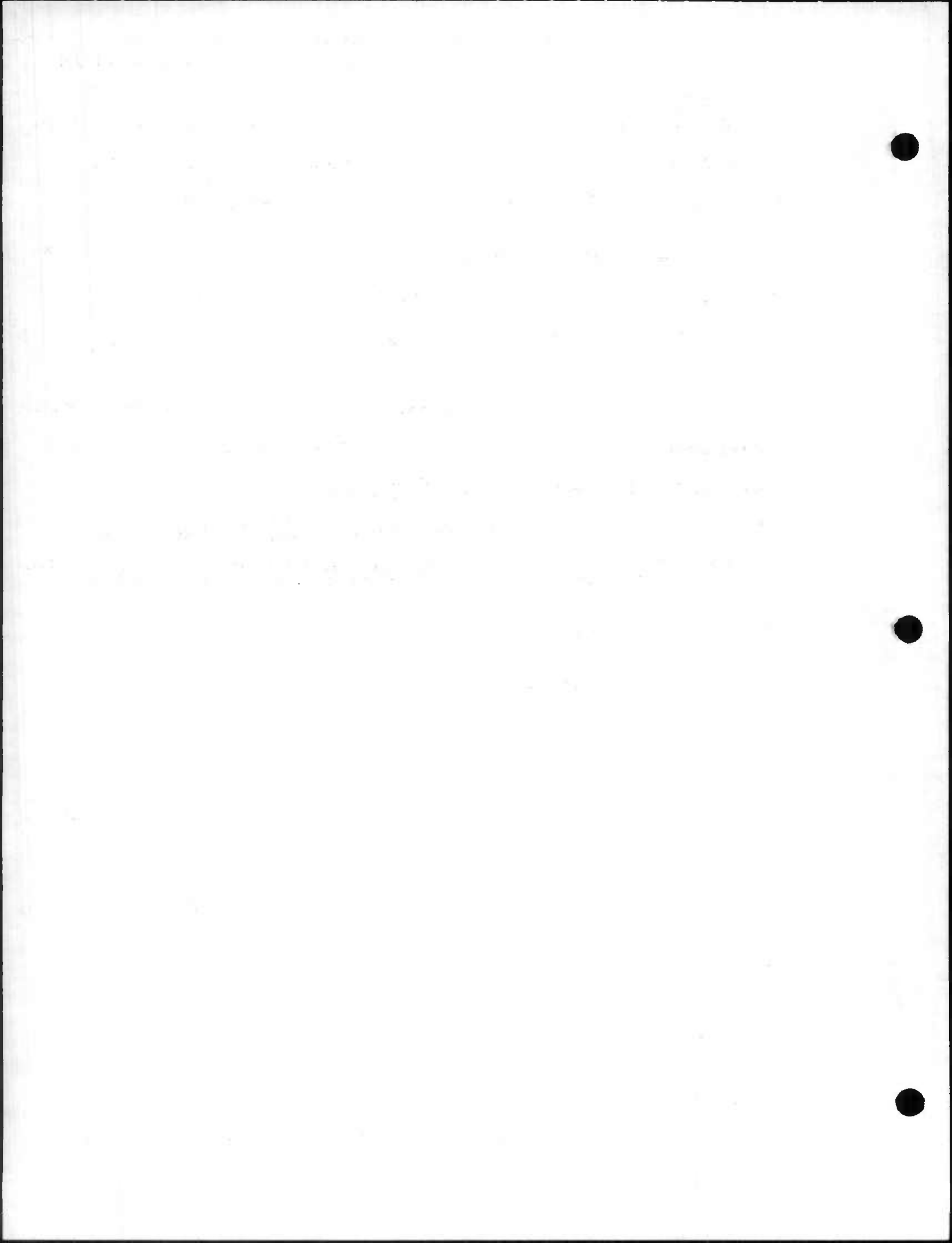
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22104

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Antonette J. Waclawski				2. Date of Death Month July Day 3 , Year 1997		3. Time of Death 6:20 pm																													
	4a. Facility Name (If not institution, give street and number) 354 Oak Drive				4b. City, Town, or Location of Death Arnold		4c. County of Death Anne Arundel																													
Funeral Director	5. Social Security Number 217-12-7340		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) June 13, 1911																													
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Arnold																													
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																															
	10e. Street and Number 354 Oak Drive				10f. Zip Code 21012		10g. Citizen of What Country? USA																													
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Treasurer		16b. Kind of Business/Industry Family Plumbing Company																															
	17. Father's Name (First, Middle, Last) Walter Dombrowski				18. Mother's Name (First, Middle, Maiden Surname) Julia Petrowski																															
	19a. Informant's Name/Relationship (Type, Print) Joseph Waclawski/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 354 Oak Drive Arnold, MD 21012																															
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial		Data July 7, 1997		20c. Location - City or Town, State Elkridge, MD																													
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146																															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																			
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) e. PNEUMONIA Due to (or as a consequence of): f. SEVERE DEMENTIA Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): </td> <td colspan="7"> 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown </td> </tr> <tr> <td colspan="7"> 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> </tr> <tr> <td colspan="7"> 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> </tr> <tr> <td colspan="7"> 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) e. PNEUMONIA Due to (or as a consequence of): f. SEVERE DEMENTIA Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Immediate Cause (Final disease or condition resulting in death) e. PNEUMONIA Due to (or as a consequence of): f. SEVERE DEMENTIA Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																																			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																				
<table border="1"> <tr> <td colspan="4">26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> <td colspan="4">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined</td> </tr> <tr> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="4">28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined																																
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																														
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																				
29b. Signature and title of certifier 				29c. License number 041339		29d. Date signed (Month, Day, Year) 7-5-97																														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANIE HEMS; 277 PENNSYLVANIA FARM ROAD ARNOLD MD 21012																																				
31. Date filed (Month, Day, Year) JUL 10 1997				32. Registrar's Signature 																																



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22105

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lillian Shirley Welch				2. Date of Death Month July Day 4 Year 1997		3. Time of Death 3:05pm		
	4a. Facility Name (If not institution, give street and number) Physicians Memorial Hospital				4b. City, Town, or Location of Death La Plata		4c. County of Death Charles		
Funeral Director	5. Social Security Number 220-24-3885		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 05-21-1928	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md		10b. County Charles		10c. City, Town or Location Indian Head		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 624 Elder Place				10f. Zip Code 20640		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12) Collega (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Her Home		
	17. Father's Name (First, Middle, Last) Harry Mattingly				18. Mother's Name (First, Middle, Maiden Surname) Mary Emily DeLozier				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sheila Lundstrom/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Elder Place Indian Head, Md. 20640				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 07-09-97 Cheltenham, Md.		20c. Location - City or Town, State		Approximate Interval Between Onset and Death		
	21. Signature of Funeral Service Licensee  Moo668				22. Name and Address of Facility Williams Funeral Home P.A. 4270 Hawthorne Road, Indian Head, Md. 20640				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; align-items: flex-start;"> <div style="margin-right: 10px;"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </div> <div> a. Necrosis of colon Due to (or as a consequence of): b. Severe metabolic acidosis Due to (or as a consequence of): c. Septic shock Due to (or as a consequence of): d. gangren of rectum s/p herniectomy </div> </div>								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D45737		29d. Date signed (Month, Day, Year) 7/4/97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nimaladevi Gurusamy, MD 605 East Charles Street, La Plata, Maryland 20646									
31. Date filed (Month, Day, Year) JUL 1 0 1997		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

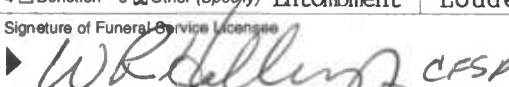
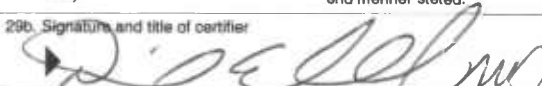
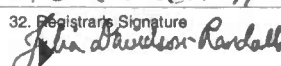
Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) KATHERINE ANNA WOOD				2. Date of Death Month Day Year July 4, 1997		3. Time of Death 2:25 PM	
4a. Facility Name (If not institution, give street and number) 4207 Coulbourne Mill Road				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
5. Social Security Number 215-16-6114		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) July 9, 1923	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 4207 Coulbourne Mill Road		10f. Zip Code 21804		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Library Assistant/Teachers Aide		16b. Kind of Business/Industry Education		17. Father's Name (First, Middle, Last) Clarence Blucher	
18. Mother's Name (First, Middle, Maiden Surname) Katherine Lang		19a. Informant's Name/Relationship (Type, Print) Charles B. Wood/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4207 Coulbourne Mill Rd., Salisbury, MD 21804		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment	
20b. Place of Disposition (Name of cemetery, crematory or other place) Louden Park Cemetery		20c. Location - City or Town, State Baltimore, MD		20d. Date 7/8/97		21. Signature of Funeral Service Licensee  W. R. Hollaway CFSP	
22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Colon Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 3yrs		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier  David C. Carroll MD		29c. License number D26278		29d. Date signed (Month, Day, Year) 7-7-97		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David Carroll MD 145 E. Carroll St. Salisbury MD 21801	
31. Date filed (Month, Day, Year) JUL 08 1997		32. Registrar's Signature  John Davidson-Randall		33. Date of Death (Month, Day, Year) July 4, 1997		34. Time of Death 2:25 PM	

To Be Completed by Funeral Director

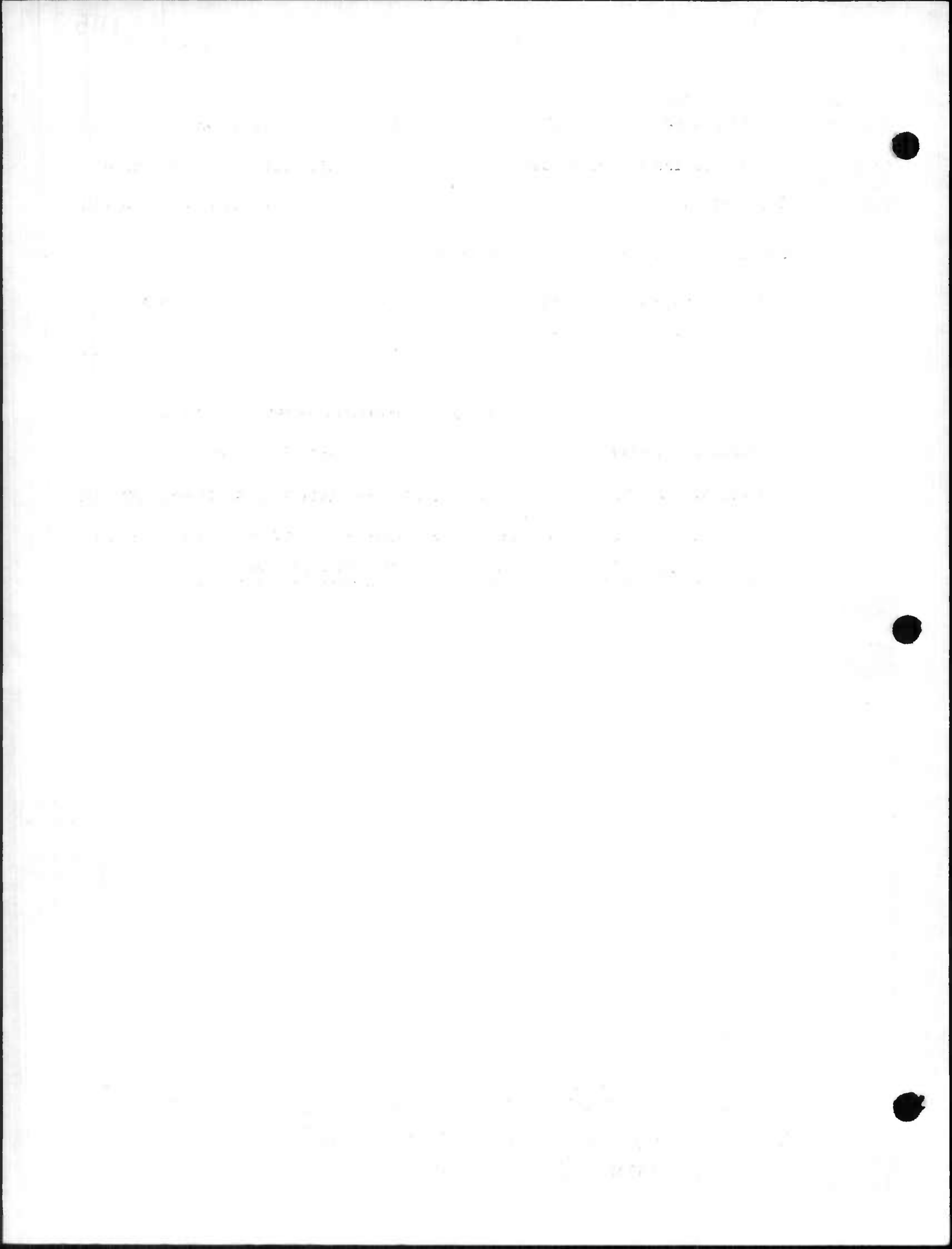
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22107

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edwin D. Wilson				2. Date of Death Month <u>June</u> Day <u>30</u> Year <u>1997</u>				3. Time of Death <u>2105</u>	
	4a. Facility Name (If not institution, give street end number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 221-07-9703		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 9, 1914		9. Birthplace (State or Foreign Country) Delaware	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Delaware		10b. County Sussex		10c. City, Town or Location Georgetown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street end Number Rt. 1 Box 286				10f. Zip Code 19947		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 41-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) weighmaster				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) weighmaster			16b. Kind of Business/Industry poultry industry		
	17. Father's Name (First, Middle, Last) William Wilson				18. Mother's Name (First, Middle, Maiden Surname) Bessie Veasey					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Diane C. Warrington				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rt. 9, Box 270, Millsboro, Del. 19966					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Millsboro Cemetery		Data 7/3/97		20c. Location - City or Town, State Millsboro, Delaware			
	21. Signature of Funeral Service Licensee <i>Richard T. Watson</i>				22. Name and Address of Facility Watson Funeral Home, Millsboro, Delaware					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. MULTISYSTEM ORGAN FAILURE Due to (or as a consequence of): b. RENAL FAILURE Due to (or as a consequence of): c. HEART FAILURE Due to (or as a consequence of): d. MESENTERIC OCCLUSION Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number 220000		29d. Date signed (Month, Day, Year) 7/1/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Craig T. Schreier M.D. 560 Riverside Dr. Salisbury MD										
31. Date filed (Month, Day, Year) JUL 08 1997										
32. Registrar's Signature <i>[Signature]</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

EDWIN D. Wilson
Division of Vital Records, P.O. Box 68760,

Full Page

... ..
... ..
... ..

... ..
... ..

... ..
... ..

... ..
... ..

... ..
... ..

... ..
... ..

... ..
... ..

... ..
... ..

... ..
... ..

... ..
... ..

... ..
... ..

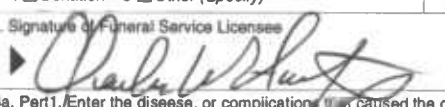
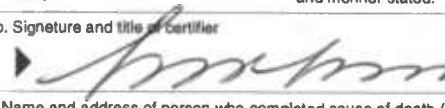
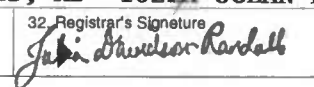
... ..
... ..

... ..
... ..

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22108

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OLIVE MAE WEST				2. Date of Death Month Day Year JULY 02 1997		3. Time of Death 10:40 PM	
	4a. Facility Name (If not institution, give street and number) BERLIN NURSING & REHABILITATION CENTER				4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 218-05-7285		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 21, 1908	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County WORCESTER		10c. City, Town or Location BERLIN			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 8 GRACE STREET				10f. Zip Code 21811		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS		16b. Kind of Business/Industry CLOTHING		
17. Father's Name (First, Middle, Last) WILLIAM JOSHUA QUILLEN				18. Mother's Name (First, Middle, Maiden Surname) EDITH TRUITT				
19a. Informant's Name/Relationship (Type, Print) MADELINE H. MOORE/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 GRACE STREET, BERLIN, MARYLAND 21811				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BUCKINGHAM PRESBYTERIAN		Date 7/6/97		20c. Location - City or Town, State BERLIN, MARYLAND		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Cerebrovascular acc. Due to (or as a consequence of): b. Arteriosclerosis. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 Day -
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension 2nd Fr Onal CHF 1+7pgb						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D02026		29d. Date signed (Month, Day, Year) 7/3/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FEDERICO G. ARTHE, MD 1622A OCEAN PINES BERLIN, MD 21811 410-641-4400								
31. Date filed (Month, Day, Year) JUL 07 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

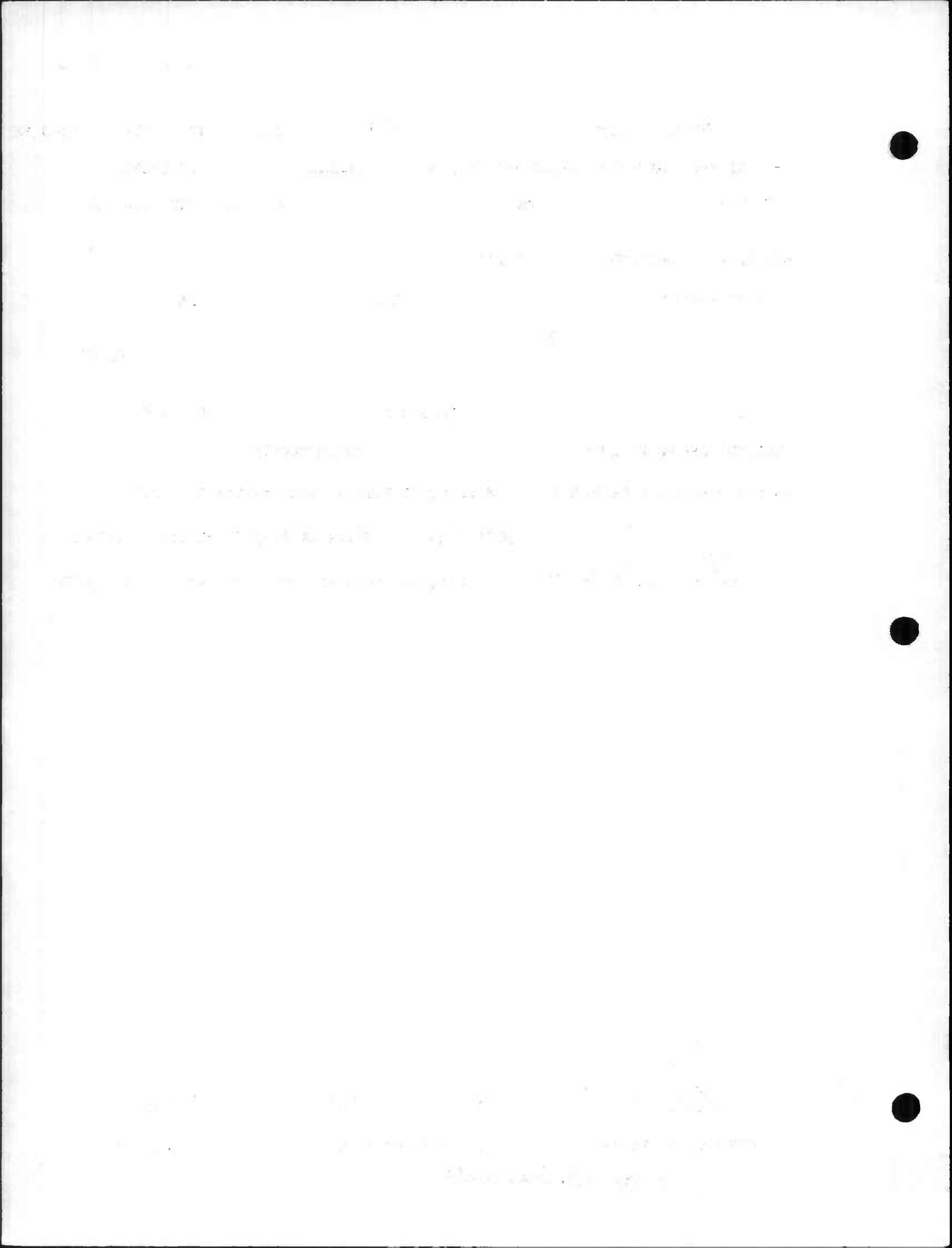
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 87 22109

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Watson Ernest Wallace** 2. Date of Death **July 8, 1997** 3. Time of Death **10:30 am**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **William Hill Health Care Center** 4b. City, Town, or Location of Death **Cambridge** 4c. County of Death **Dorchester**
5. Social Security Number **215-18-4456** 6. Sex **1 M 2 F** 7. Age (In yrs. last birthday) **87** Yrs. 8. Date of Birth (Month, Day, Year) **Dec. 13, 1909** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent
10a. State **Maryland** 10b. County **Dorchester** 10c. City, Town or Location **Toddville** 10d. Inside City Limits **1 Yes 2 No**

10e. Street and Number **Toddville Pond Road** 10f. Zip Code **21672** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status **1 Never Married 2 Married 3 Widowed 4 Divorced** 12. Was Decedent Ever in U.S. Armed Forces? **1 Yes 2 No** 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) **1 Yes 2 No** 14. Race - American Indian, Black, White, etc. **White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12) 08** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Waterman** 16b. Kind of Business/Industry **Shellfish**

17. Father's Name (First, Middle, Last) **Joseph E. Wallace** 18. Mother's Name (First, Middle, Maiden Surname) **Nellie Meekins**

19a. Informant's Name/Relationship (Type, Print) **Dorothy E. Miller-Daughter** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **2609 Hoopers Island Rd., Fishing Creek, MD 21634**

20a. Method of Disposition **1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)** 20b. Place of Disposition (Name of cemetery, crematory or other place) **Dorchester Mem. Pk.** 20c. Location - City or Town, State **7-11-97 Cambridge, MD**

21. Signature of Funeral Service Licensee *[Signature]* 22. Name and Address of Facility **Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) **- COPD (chronic obstructive pulmonary disease) years**
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last **- Severe malnutrition months**
Due to (or as a consequence of):
- Possible Myocardial ischemia 15 min
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- Hip fixation
- Macrocytic Anemia
- Chronic renal failure

23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? **1 Yes 2 No** 24b. Were autopsy findings available prior to completion of cause of death? **1 Yes 2 No**

25. Was case referred to medical examiner? **1 Yes 2 No** 26. Place of Death (Check only one)
Hospital: **1 Inpatient 2 ER/Outpatient 3 DOA** Other: **4 Nursing Home 5 Residence 6 Other (Specify)**

27. Manner of Death **1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined** 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? **1 Yes 2 No** 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) **1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.**

29b. Signature and title of certifier *[Signature]* 29c. License number **D0050987** 29d. Date signed (Month, Day, Year) **7/9/97**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Ahmed Nawar 105 Aurora Street Cambridge**

31. Date filed (Month, Day, Year) **JUL 11 1997** 32. Registrar's Signature *[Signature]*

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner

ne 97 22110

Physician
/Medical
Examiner

Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

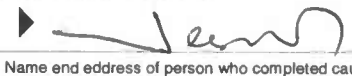
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) ALICE M. ZAIS		2. Date of Death Month JULY Day 6 Year 1997		3. Time of Death 1330							
4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany						
5. Social Security Number 216-80-6851		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Aug 16 1922		9. Birthplace (State or Foreign Country) Maryland			
10a. State Maryland		10b. County Allegany		10c. City, Town or Location Westernport		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 288 Main St.			10f. Zip Code 21562		10g. Citizen of What Country? United States						
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Unknown			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home					
17. Father's Name (First, Middle, Last) John Wilson				18. Mother's Name (First, Middle, Maiden Surname) Louise B. Holler							
19e. Informant's Name/Relationship (Type, Print) Marvin Q Zais Sr.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 288 Main St. Westernport, Md. 21562								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Potomac Memorial Gardens		Date 7-9-97		20c. Location - City or Town, State Keyser, WV.					
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Boal Funeral Home 111 Church St. Westernport, Md.								
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute renal failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 10 days			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Diabetes Mellitus, Gastrointestinal Bleeding ; Urinary Tract Infection						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 11/11/97		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D21244		29d. Date signed (Month, Day, Year) JULY 7, 1997					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan, M.D. Frostburg Plaza Frostburg MD 21532											
31. Date filed (Month, Day, Year) JUL 11 1997		32. Registrar's Signature 									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22111

Ethel Zepp

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

Ethel

Elizabeth Zepp

2. Date of Death

Month

Day

Year

July

2 1997

3. Time of Death

5:45 AM

4a. Facility Name (If not institution, give street and number)

Long View Nursing Home

4b. City, Town, or Location of Death

Manchester

4c. County of Death

Carroll

5. Social Security Number

219-44-5722

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

10/13/03

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore County

10c. City, Town or Location

Upperco

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

5412 Arcadia Ave.

10f. Zip Code

21155

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

John Edward Rote

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Elizabeth Huff

19a. Informant's Name/Relationship (Type, Print)

Gene Geist Zepp

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5412 Arcadia Ave. Upperco, MD 21155

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hampstead Cemetery

Date

7/5/97

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

Stevens W. Elmer

22. Name and Address of Facility

934 S. Main St
Eline Funeral Home Hampstead, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cerebral Vascular Accident 2 Min

Due to (or as a consequence of):

b.

atrial fibrillation & emboli

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

C.A.H.D.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. H. Foard MD

29c. License number

D02386

29d. Date signed (Month, Day, Year)

7/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. H. Foard MD 3223 Main St Manchester, MD 21102

31. Date filed (Month, Day, Year)

JUL 03 1997

32. Registrar's Signature

J. L. Harrison-Randall

State
Registrar

11121 52

11121 52

11121 52

11121 52

11121 52

11121 52

11121 52

11121 52

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Items: 21,22 per F.H. G-749 7/22/97 reb

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William C. Brown

2. Date of Death

Month Day Year
July 16, 1997

3. Time of Death

4:15p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4222 Evans Chapel Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-07-3653

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 30, 1920 MD.

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4222 Evans Chapel Road

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Baltimore City
Dept. Of. Education

17. Father's Name (First, Middle, Last)

Charles Milton Brown

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Gaither Tolliver

19a. Informant's Name/Relationship (Type, Print)

William Curry Brown son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7202 Pinecrest Road Baltimore, Md. 21228

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

655 W. BALTIMORE ST.
STATE ANATOMY BOARD Nutter Funeral Homes, Inc. 21201
2501 Gwynns Falls PKWY Baltimore, Md. 2121623a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death7/16/97
2/16/97
7/16/97

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William C. Brown M.D.

29c. License number

D08143

29d. Date signed (Month, Day, Year)

7/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KUBBERJ. MITCHELL, M.D. 1230 DROID HILL AVE.

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inpatient: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22113

Item: 10b per FH G-749 7/22/97 dh
Items: 24a, 25, 26, 27, 29a per MD G-749 7/22/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedant's Name (First, Middle, Last) ROBERT BANKS,		2. Date of Death Month 06 Day 22 Year 97		3. Time of Death 6⁰¹ A.M.			
4a. Facility Name (If not institution, give street and number) Edw.W.McCready Memorial Hospital		4b. City, Town, or Location of Death Crisfield		4c. County of Death Somerset			
5. Social Security Number 215-26-6078	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 22, 1931		
9. Birthplace (State or Foreign Country) unknown							
Usual Residence of Decedant							
10a. State Maryland	10b. County Somerset	10c. City, Town or Location Crisfield		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 201 Hall Highway		10f. Zip Code 21817		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown			
17. Father's Name (First, Middle, Last) unknown		18. Mother's Name (First, Middle, Maiden Surname) unknown					
19a. Informant's Name/Relationship (Type, Print) unknown		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) in state		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE FROM Due to (or as a consequence of): b. PULMONARY EDEMA, AND PNEUMONIA Due to (or as a consequence of): c. SEPSIS Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M			
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier [Signature] M.D.		29c. License number D0051864		29d. Date signed (Month, Day, Year) 06-22-97			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKINWOLE AWOJO M.D. McCREADY MEMORIAL HOSPITAL - CRISFIELD, MD 21817							
31. Date filed (Month, Day, Year)		32. Registrar's Signature [Signature]					

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

EDWARD BUDDEMEYER

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD ULRICH BUDDEMEYER

2. Date of Death
Month Day Year

JULY 19 1997

3. Time of Death

11:05 PM

4a. Facility Name (If not institution, give street and number)

EASTON MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral
Director

5. Social Security Number

213-30-6022

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

May 16, 1934

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Glen Arm

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11507 Notchcliff Rd.

10f. Zip Code

21057

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 3/57-9/5713. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: USA

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nuclear Physicist

16b. Kind of Business/Industry

University of Md.

17. Father's Name (First, Middle, Last)

William

Buddemeyer

18. Mother's Name (First, Middle, Maiden Summa)

Margaret

Ulrich

19a. Informant's Name/Relationship (Type, Print)

Mrs. Freda Buddemeyer/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11507 Notchcliff Rd. Glen Arm, Md. 21057

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Memorial

Date

7/24/97

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?
inspection1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

o.c.m.e.

29d. Date signed (Month, Day, Year)

july 20, 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22115

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Elisabeth S. Bramble				2. Date of Death Month July Day 20 Year 1997				3. Time of Death 3:10 p.m.					
4a. Facility Name (If not institution, give street and number) Wilson Health Care Center				4b. City, Town, or Location of Death Gaithersburg				4c. County of Death Montgomery					
5. Social Security Number 017-36-9541		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) July 23, 1904		9. Birthplace (State or Foreign Country) Germany	
Usual Residence of Decedent													
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. Street and Number 14221 Cantrell Road				10f. Zip Code 20905				10g. Citizen of What Country? United States					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				18b. Kind of Business/Industry Household					
17. Father's Name (First, Middle, Last) Adam Schlier						18. Mother's Name (First, Middle, Maiden Surname) Katharine Denhard							
19a. Informant's Name/Relationship (Type, Print) Beatrice Simpson / Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14221 Cantrell Rd., Silver Spring, MD 20905-4423							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 7/23/97		20c. Location - City or Town, State Baltimore, Maryland					
21. Signature of Funeral Service Licensee <i>Opine J. Phillips</i>						22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, MD 21229							
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Vascular Accident Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death Days	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Elliot R. Goldstein</i>				29c. License number D0 3581		29d. Date signed (Month, Day, Year)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elliot R. Goldstein 9410 Old Georgetown Road, Bethesda, Md. 20814													
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature <i>J. Davidson-Randall</i>									

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22116

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Maria R. Briggs

2. Date of Death

Month
JULYDay
15Year
1997

3. Time of Death

10:00 am

4a. Facility Name (If not institution, give street and number)

St. Agnes Hoapital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

065-18-1405

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 23, 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2312 Rockwell Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Gennaro Annunziato

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Nunziato

19a. Informant's Name/Relationship (Type, Print)

Craig T. Briggs (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6408 Kent Point Road Stevensville, Maryland 21666

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Woodlawn Cemetery July 18, 1997 Woodlawn, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. Craig Withers

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, Maryland 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. DISSEMINATED INTRAVASCULAR COAGULATION

24 HRS

Due to (or as a consequence of):

b. MYELOPROLIFERATIVE DISORDER

5 MONTHS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bert F. Morton, M.D.

29c. License number

D08949

29d. Date signed (Month, Day, Year)

July 15, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Bert F. Morton St. Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

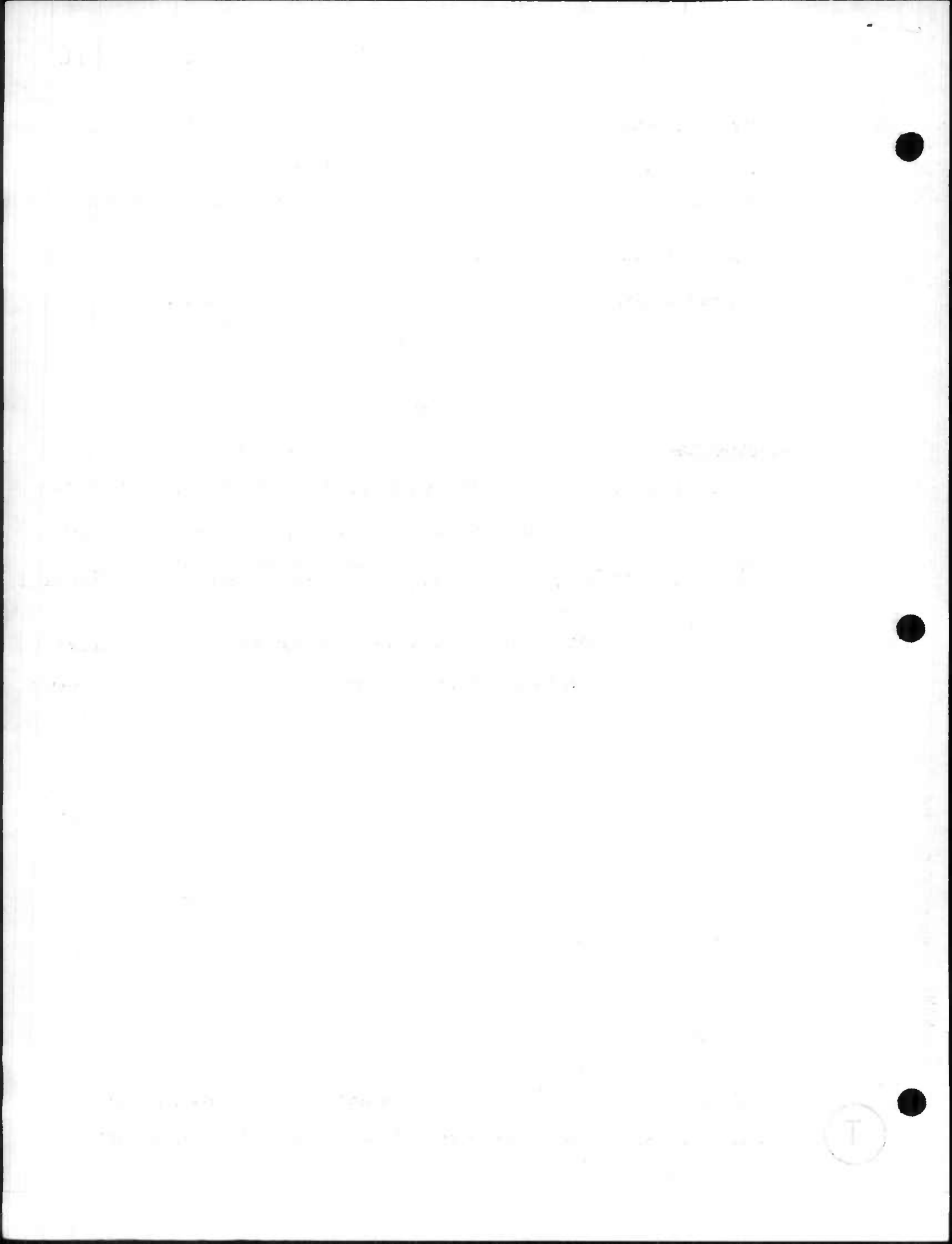
State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitNAME: BRIGGS, MARIA
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

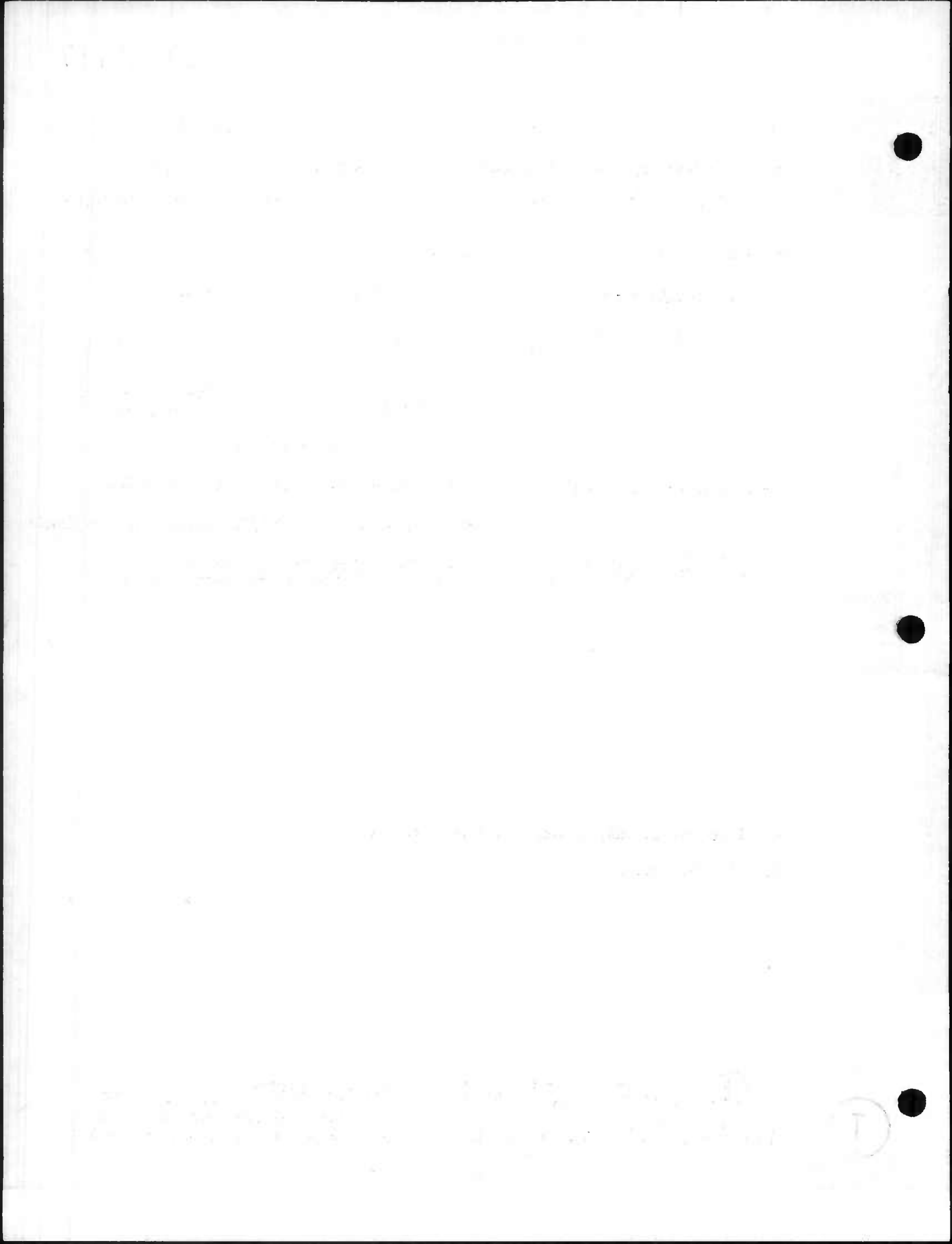
Reg. No.

97 22117

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alfred Bell				2. Date of Death Month July Day 19 Year 1997		3. Time of Death 6:48 am	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-03-7564		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Aug 13, 1919	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1536 Baldwin Street		10f. Zip Code 21211		10g. Citizen of What Country? U.S.A	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry Fred Gross Fuel Oil Co.			
	17. Father's Name (First, Middle, Last) unk		18. Mother's Name (First, Middle, Maiden Surname) Anna Giddings					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joseph B. Bright (Grandson)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1536 Baldwin Street, Baltimore, Md. 21211					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery		Date 7/23/97		20c. Location - City or Town, State Baltimore, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 24 hours					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple pneumonias, Congestive Heart Failure, Atrial Fibrillation						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number RES-000		29d. Date signed (Month, Day, Year) July 21, 1997	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Christopher G. Azoli, M.D.		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Johns Hopkins Bayview Medical Center 4940 Eastern Ave, Baltimore, MD 21224					
	31. Date filed (Month, Day, Year) JUL 22 1997		31. Date filed (Month, Day, Year) 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22118

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mattie Benesch Baker

2. Date of Death

Month Day Year
July 17, 1997

3. Time of Death

11:00 P.M.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Manor Care Towson

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore County

5. Social Security Number

212-28-4619

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 17, 1900

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

7411 Chesapeake Road

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

William Edward Messick

18. Mother's Name (First, Middle, Maiden Surname)

Lula Florence Young

19a. Informant's Name/Relationship (Type, Print)

Lois Anne Crayton/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7411 Chesapeake Road, Baltimore, Maryland 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Cemetery

Date

7/19/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Juanita R Thomas

22. Name and Address of Facility

John C. Miller, Inc.

6415 Belair Road, Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Essential Thrombocytosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Monoclonal gammopathy of unknown significance

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William D. McConner MD

29c. License number

D 42129

29d. Date signed (Month, Day, Year)

July 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William McConner 500 W. University Baltimore

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Gordon-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

81/7-1-

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22119

Item:1 per MD G-749 7/21/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THEODORE
THEODORE JUNIOR ROSEVELT BRACEY2. Date of Death
Month Day Year

July 12, 1997

3. Time of Death
1:45 a.m.

4a. Facility Name (If not institution, give street and number)

CARDINAL SHEAN STELLA MARIS

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-26-7206

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

JAN 6, 1939

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

633 WILLOW AVE

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

MAINTENANCE HELPER

16b. Kind of Business/Industry

BLACK & DECKER

17. Father's Name (First, Middle, Last)

THEODORE BRACEY

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE BELLE DRAKEFORD

19a. Informant's Name/Relationship (Type, Print)

ANNIE BELL BRACEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

633 WILLOW AVE BALTO, MD 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ARBUTUS MEM PK

Date

JUL 16
1997

20c. Location - City or Town, State

ARBUTUSMD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BETTS FUNERAL HOME

1129 N. CAROLINE ST BALTO, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. RENAL CELL CA. WITH METS TO LUNG

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D15564

29d. Date signed (Month, Day, Year)

7.14.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. EDDIE NAKHUDA, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

T

2112

T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

07 22120

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPHINE SCOTT CURTIS				2. Date of Death Month JULY Day 15 Year 1997				3. Time of Death 3:45 P.M.	
	4a. Facility Name (If not institution, give street and number) 414 E. PENNSYLVANIA AVENUE				4b. City, Town, or Location of Death TOWSON				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 213 40 0787		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) MAY 20. 1907		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County BALTIMORE		10c. City, Town or Location TOWSON				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 414 E. PENNSYLVANIA AVENUE				10f. Zip Code 21204		10g. Citizen of What Country? U.S. OF A.			
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A		College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC WORKER			16b. Kind of Business/Industry PRIVATE FAMILY		
	17. Father's Name (First, Middle, Last) JAMES TAYLOR SCOTT				18. Mother's Name (First, Middle, Maiden Surname) LOUISA THOMAS SCOTT					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CAROLYN LE VERE (GREAT NIECE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210A WINTERS LANE CATONSVILLE, MD. 21228					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PLEASANT REST CEM.		Date 7/21/97		20c. Location - City or Town, State TOWSON, MARYLAND CO			
	21. Signature of Funeral Service Licensee <i>Lewis T. Gwynn</i>				22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-639 4517 PARK HEIGHTS AVE. BALTO..MD.					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. aortic valve stenosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and Title of certifier <i>Jeffery Cool M</i>				29c. License number 034650		29d. Date signed (Month, Day, Year) 7/16/97			
State Registrar	30. Name and address of person who completed cause of death (item 23e) (Type, Print) Jeffery Cool 9712 Belair Rd. Balto, Md. 21236									
	31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature <i>Julia Davidson-Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified and at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

T

Handwritten signature

Handwritten text at the bottom of the page

7

97-4037-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22121

HELEN

CUMMINGS Items: 23a part I, II, 27, 28a-f per MEO

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **HELEN DENISE CUMMINGS**
2. Date of Death Month **JULY** Day **19** Year **1997** 3. Time of Death **4:27 P.M.**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **SINAI HOSPITAL**
4b. City, Town, or Location of Death **BALTIMORE** 4c. County of Death **n/a**

5. Social Security Number **214-78-4927** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **29** Yrs. 8. Date of Birth (Month, Day, Year) **JUNE 2, 1968** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent
10a. State **MD** 10b. County **n/a** 10c. City, Town or Location **BALTIMORE** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **4612 REISTERSTOWN ROAD,** 10f. Zip Code **21215** 10g. Citizen of What Country? **UNITED STATES**

11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: **XX** 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **BLACK**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **10th** College (14 or 5+) **-** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **LABORER** 16b. Kind of Business/Industry **unemployed**

17. Father's Name (First, Middle, Last) **RUDOLPH CUMMINGS** 18. Mother's Name (First, Middle, Maiden Surname) **LOUISE BOYD**

19a. Informant's Name/Relationship (Type, Print) **LOUISE CUMMINGS-MOTHER** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **4612 REISTERSTOWN ROAD, BALTO., MD #15**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **WESTERN STAR CEMETERY 7-24-97 CATONSVILLE, MD** Data 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee *Sharon S. Allen* 22. Name and Address of Facility **WM. C. MARCH FH.-4300 WABASH AVENUE**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **NARCOTIC (METHADONE) INTOXICATION** Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last **Due to (or as a consequence of):**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **MULTIPLE OBSCESSES OF SPLEEN LIVER AND LUNG DUE TO CHRONIC NARCOTISM**

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown 24a. Was an autopsy performed? ☒ Yes ☐ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☒ Yes ☐ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☒ Could not be determined 28a. Date of Injury (Month, Day, Year) **7/19/97** 28b. Time of Injury **1:30** P **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred **subject ingested drugs**

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **home** 28f. Location (Street and Number or Rural Route Number, City or Town, State) **4612 Reisterstown Road, Baltimore, Md.**

29a. Certifier ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

29b. Signature and title of certifier *Stephen S. Radentz, MD* 29c. License number **O.C.M.E.** 29d. Date signed (Month, Day, Year) **JULY 20, 1997**

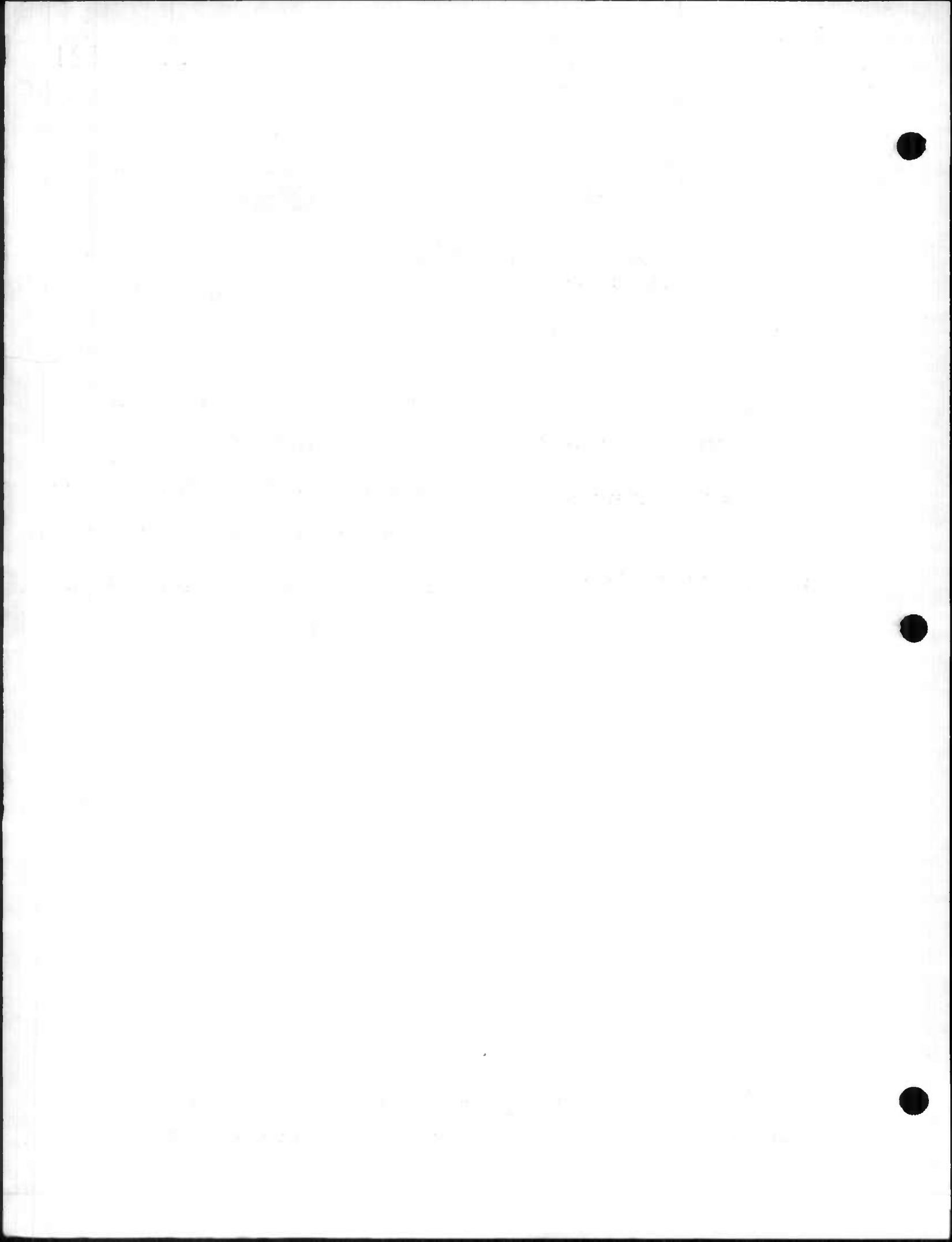
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201**

31. Date filed (Month, Day, Year) **JUL 22 1997** 32. Registrar's Signature *[Signature]*

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22122

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Coleman

2. Date of Death

Month

Day

Year

July 18 1997

3. Time of Death

8:10 AM

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

228-38-2130

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

11/7/1922

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4107 SPRINGDALE AVENUE

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Augustus Walter Jordan, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Christina Coleman

19a. Informant's Name/Relationship (Type, Print)

Ora Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3909 Barrington Road, Balto., MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion Cemetery

Date

7/23

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Leroy O. Dyett

22. Name and Address of Facility

LEROY O. DYETT & SON FUNERAL HM, P.A.
4600 LIBERTY HEIGHTS AVE., BALTO. 2120723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Pulmonary Tuberculosis

Due to (or as a consequence of):

b.

Cardiac Arrhythmias

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

George E. Wicks III M.D.

29c. License number

D41365

29d. Date signed (Month, Day, Year)

July 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Wicks III M.D. 2600 Liberty Heights Ave 21215

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GARY

COOPER

2. Date of Death

Month

Day

Year

7

18

97

3. Time of Death

2:35 AM

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-62-1453

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

42

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

MAR

22

1955

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1000 N. Bentalou Street

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Osborne Cooper

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Hudson

19a. Informant's Name/Relationship (Type, Print)

Ryan R. Saunders/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8108 Salt Lake Dr. Randallstown, MD 21244

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Nema of crematory, crematory or other place)

Metro Crematory, Inc. 7/19/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Brain mass

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acquired Immunodeficiency Syndrome

End stage Renal Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Schipper MD

29c. License number

D42683

29d. Date signed (Month, Day, Year)

7/18/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RADCLIFFE M THOMAS M.D. 4500 W NORTHERN PKWY, BALTIMORE, MD

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

21215

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

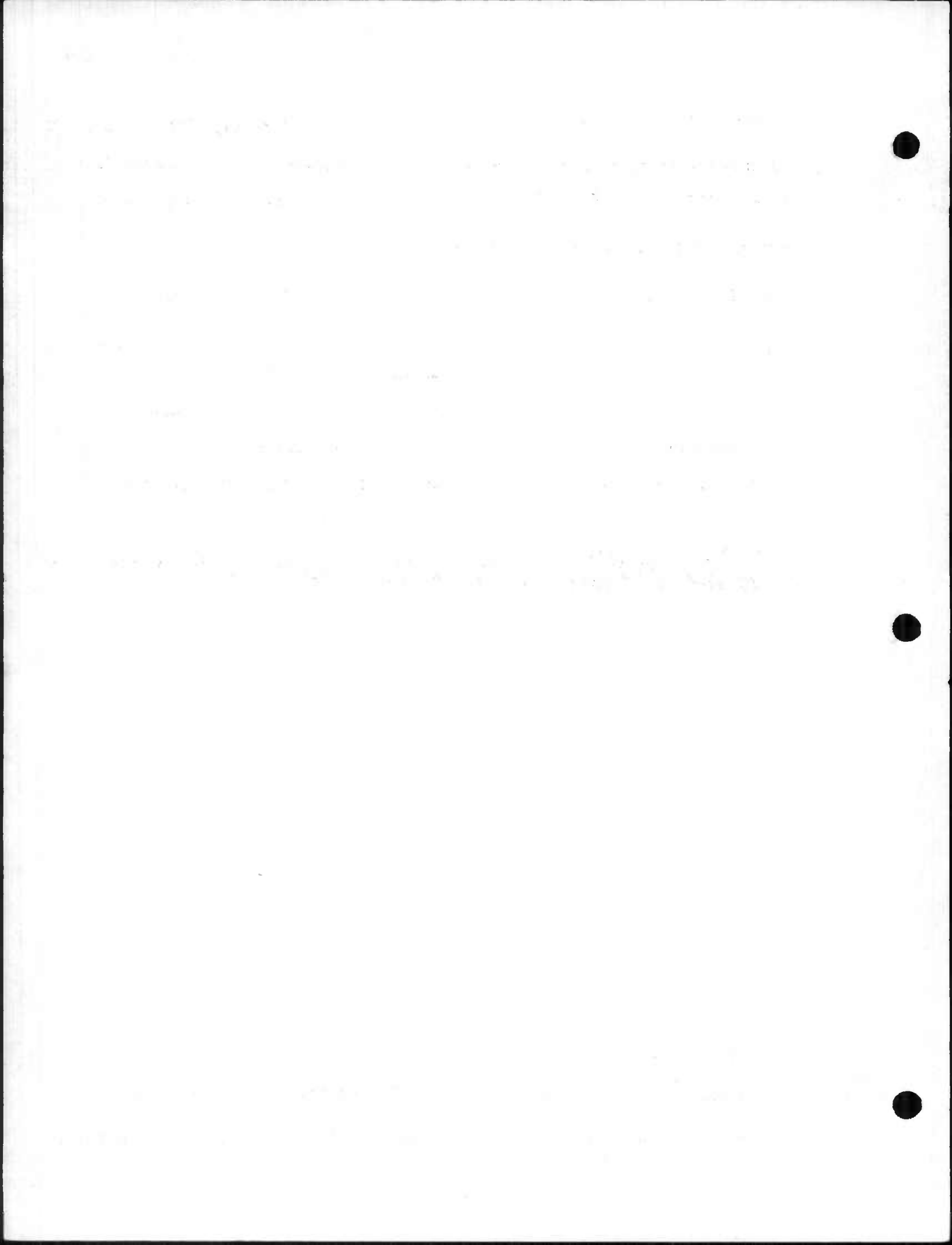
97 22124

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen G. Chamberlain						2. Date of Death Month Day Year June 13, 1997		3. Time of Death 8:30 PM	
	4a. Facility Name (If not Institution, give street and number) Deaton Specialty Hospital and Home						4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 212-05-5578		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 19, 1899		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore City		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 600 Light Street				10f. Zip Code 21230		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teller			16b. Kind of Business/Industry Bank		
	17. Father's Name (First, Middle, Last) William Scheel				18. Mother's Name (First, Middle, Maiden Surname) Susan Reinig					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Orville Scheel/brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Ward Circle, Sun City, Florida 33573					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Coronary Artery Disease Due to (or as a consequence of):</p> <p>b. Congestive Heart Failure Due to (or as a consequence of):</p> <p>c. Coronary Artery Disease Due to (or as a consequence of):</p> <p>d. Coronary Artery Disease Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>7 months</p> <p>10 years</p> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number D38675		29d. Date signed (Month, Day, Year) 7/11/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL MESHULAM 1147 S HANOVER ST BALT MD 21230										
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22125

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Bruce Cole

2. Date of Death

Month Day Year
July 20, 1997

3. Time of Death

5:40 PM

4a. Facility Name (If not institution, give street and number)

2034 Larkhall Road

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-14-7904

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 9, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2034 Larkhall Road

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Office

16b. Kind of Business/Industry

Law Enforcement

17. Father's Name (First, Middle, Last)

James Arthur Cole

18. Mother's Name (First, Middle, Maiden Surname)

Cathryn Shaunessy

19a. Informant's Name/Relationship (Type, Print)

Mrs. Georgia A. Cole

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2034 Larkhall Road Dundalk, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Memorial Park 07-24-97 Middle River, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Avenue Dundalk, Maryland 21222

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

1 year

c. Coronary Artery Disease

Due to (or as a consequence of):

2 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Chronic Obstructive Pulmonary Disease,
Renal Artery Stenosis
Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accidental 6 ☐ Could not be determined
3 ☐ Suicidal 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D51185

29d. Date signed (Month, Day, Year)

7/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Colleen Christmas MD, 5505 Hopkins Bayview Circle, Baltimore MD 21224

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

T

97-4032-510
B.K.S
DARRYL DIGGS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

9722126

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DARRYL DWAYNE DIGGS				2. Date of Death Month Day Year JULY 19, 1997		3. Time of Death 1527 PM		
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL E.R.				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a		
Funeral Director	5. Social Security Number <i>XXX</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 22 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 28, 1975	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 3302 W. GARRISON AVENUE				10f. Zip Code 21215		10g. Citizen of What Country? UNITED STATES			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry unemployed			
17. Father's Name (First, Middle, Last) STEVE DIGGS				18. Mother's Name (First, Middle, Maiden Surname) JOYCELYN HOLDEN					
19a. Informant's Name/Relationship (Type, Print) CLEMENTINE BULLOCK				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 MILL PAINT RD., BALTIMORE MD 21117					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHALL MEMORIAL GARDENS 7-25 DUNDALK, MD							
21. Signature of Funeral Service Licensee <i>Shana Stokes</i>				22. Name and Address of Facility WM. C. MARCHER - 4300 WABASH A VENUE					
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 7-19-97		28b. Time of Injury unknown		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject was shot	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street		28f. Location (Street and Number or Rural Route Number, City or Town, State) 5000 black Denmore Baltimore City, Maryland					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Stylish N. Nactz, MD</i>							29c. License number O.C.M.E
		29d. Date signed (Month, Day, Year) JULY 20, 1997							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature <i>John Paulson-Randall</i>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22127

Item 7 per FH FilmG749 7-22-97 rja

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William H Dowling

2. Date of Death

July 18 1997

Day Year

3. Time of Death

0534

4a. Facility Name (If not institution, give street and number)

UMMS

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-56-7268

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

8 11

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-7-51

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

440 S. Augusta Avenue, Baltimore

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Deputy Sheriff

16b. Kind of Business/Industry

Police

17. Father's Name (First, Middle, Last)

William Henry Dowling Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Opal Virginia Price

19a. Informant's Name/Relationship (Type, Print)

Opal Dowling/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

440 S. Augusta Avenue, Baltimore, Md. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Pk.

Date

7-21-97

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home
at Meadowridge Memorial Park, Inc., 7250
Washington Blvd., Elkridge, Md. 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Sepsis

b.

Due to (or as a consequence of):

Cardiomyopathy

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Adam Clark, MD

29c. License number

AU4176435C9196

29d. Date signed (Month, Day, Year)

July, 18 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Adam Clark 22 S. Greene St.

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22128

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Stanley Drummond

2. Date of Death

Month Day Year
July 20, 1997

3. Time of Death

4:17 a.m.

4e. Facility Name (If not institution, give street and number)

Joseph Richey Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-22-9041

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT 31, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

301 McMechen Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: 1947-50

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Night Watchman

16b. Kind of Business/Industry

Security

17. Father's Name (First, Middle, Last)

Archie Nelson Drummond

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Gertrude Young

19a. Informant's Name/Relationship (Type, Print)

Deborah D. Drummond/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2413 Wilgry Ct. Baltimore, MD 21230

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc. 7/21/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Nasopharyngeal carcinoma

13 years

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Non-insulin diabetes mellitus

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Richey

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Hospice

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 13006

29d. Date signed (Month, Day, Year)

21 July 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas H. Powell 101 W. Read St Baltimore 21201-4905

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22129

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Deicke				2. Date of Death Month Day Year July 20, 1997		3. Time of Death 6:22 am		
	4a. Facility Name (If not institution, give street and number) Oakcrest Health Care Center				4b. City, Town, or Location of Death Parkville		4c. County of Death Balto. Co.		
Funeral Director	5. Social Security Number 261-43-7605		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 20, 1900	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Parkville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street end Number 8800 Walther Boulevard Apt. 2312				10f. Zip Code 21236		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) William Jarrett Kone				18. Mother's Name (First, Middle, Maiden Surname) Mary Miller				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) William Kone / Son				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 34 Cunningham Drive New Smyrna, FL 32168				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 7/22/97		20c. Location - City or Town, State Towson, Maryland		
	21. Signature of Funeral Service Licensee <i>Leonard J. Ruck, Inc. Funeral Home</i>				22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214				
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. GI Bleed with Anemia Due to (or as a consequence of):</p> <p>b. CVA with Multi-infarct Dementia Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>									
<p>Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.</p> <p>Dysphagia with poor po intake</p> <p>Depression ; Asthma</p>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>BAS Beamer</i>		29c. License number D47479		29d. Date signed (Month, Day, Year) 7/20/97		28f. Location (Street end Number or Rural Route Number, City or Town, State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brock Allen Beamer, Oakcrest Care Center, 8820 Walther Blvd., Baltimore									
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature <i>Galia Davidson-Randall</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

8

2011

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific requirements for record-keeping. It states that all transactions must be recorded in a timely and accurate manner, and that the records must be maintained for a minimum of five years.

3. The third part of the document discusses the role of the auditor in verifying the accuracy of the records. It states that the auditor must perform a thorough review of the records and must report any discrepancies to the appropriate authorities.

4. The fourth part of the document discusses the consequences of failing to comply with the record-keeping requirements. It states that individuals who fail to comply may be subject to fines and penalties, and that the organization may be held liable for any losses resulting from the failure.

5. The fifth part of the document discusses the importance of training and education for all personnel involved in the financial system. It states that all personnel must be trained in the proper record-keeping procedures and must be held accountable for their actions.

(1)

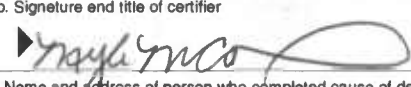
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22130

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NELLIE D. DUNCAN				2. Date of Death Month Day Year JULY 18, 1997		3. Time of Death 6:10 PM			
	4a. Facility Name (If not institution, give street and number) CHARLESTOWN CARE CENTER				4b. City, Town, or Location of Death CATONSVILLE		4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 214-40-5825		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9/28/1906	9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 709 MAIDEN CHOICE LANE				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERICAL			16b. Kind of Business/Industry ENOCH PRATT LIBRARY		
	17. Father's Name (First, Middle, Last) ASHBY T. DRUMMOND				18. Mother's Name (First, Middle, Maiden Surname) EMMA M. (WHETZEL)					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) GEORGE DORER, JR. (GREAT NEPHEW)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 MAIDEN CHOICE LANE BALTO, MD 21228					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LORRAINE PARK		Date 7/22/97		20c. Location - City or Town, State MARYLAND			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE, CATONSVILLE, MD 21228					
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic coronary artery disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. c. d. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death Years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure disorder Depression						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D30989		29d. Date signed (Month, Day, Year) July 18 1997				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Myla M Carpenter MD 711 Maiden Choice Ln Catonsville										
31. Date filed (Month, Day, Year) JUL 22 1997										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22131

Item 31 per Field Rep Film G749 7-22-97 rja

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOAN MARY EUBANK				2. Date of Death Month July Day 18 Year 1997		3. Time of Death 6:15 AM	
	4a. Facility Name (If not institution, give street and number) 3616 FAIRVIEW AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-36-3642		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) OCT 10, 1936	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 3616 FAIRVIEW AVE		10f. Zip Code 21216	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Person				16b. Kind of Business/Industry J.C. PENNEY			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Tony De Francesco				18. Mother's Name (First, Middle, Maiden Surname) Margaret Jackson			
	19a. Informant's Name/Relationship (Type, Print) Robert Butler / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 VENABLE AVE Baltimore, Md 21218			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory, or other place) Most Holy Redeemer Ch.		20c. Location - City or Town, State Baltimore, Md	
	21. Signature of Funeral Service Licensee Gray Harris				22. Name and Address of Facility CHATHAM - HARRIS Funeral Home 5340 REGISTER TOWN ROAD BALTIMORE, Md 21215			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Terminal Metastatic Lung Cancer Due to (or as a consequence of): b. Pleural Effusion Bilateral Due to (or as a consequence of): Lung Cancer c. Seizure Disorder Due to (or as a consequence of): d. Schizophrenia							Approximate Interval Between Onset and Death 4 yrs
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Dr. Muneedhe Reddy M.D.			
To Be Completed by Physician/Medical Examiner	29c. License number DH6305				29d. Date signed (Month, Day, Year) 7/18/97			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 530 N Hilton Street, Baltimore MD 21229				31. Date filed (Month, Day, Year) 07/18/97 JUL 22 1997			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature Julia Davidson-Randall				33. Date of Death (Month, Day, Year) 07/18/97			
	34. Date of Death (Month, Day, Year) 07/18/97				35. Date of Death (Month, Day, Year) 07/18/97			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97-4054-005

FREDERICK
ENDSLEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22132

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) FREDERICK WILLIAM ENDSLEY				2. Date of Death Month JULY Day 20 Year 1997		3. Time of Death 4:31A.M.	
4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
5. Social Security Number 218-44-4229		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) July 23, 1946	
9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1716 Stokesley Road		10f. Zip Code 21222		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics Craftsman		16b. Kind of Business/Industry Steel		16c. Kind of Business/Industry Steel	
17. Father's Name (First, Middle, Last) Neil Endsley				18. Mother's Name (First, Middle, Maiden Surname) Aretta M. Klatt			
19a. Informant's Name/Relationship (Type, Print) Mrs. Michelle D. Endsley				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 Stokesley Road Dundalk, Maryland 21222			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem.		20c. Location - City or Town, State 07-24-97 Owings Mills, Maryland		20d. Location - City or Town, State 07-24-97 Owings Mills, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Liver Failure Due to (or as a consequence of): b. Acetaminophen intoxication (clinical) Due to (or as a consequence of): c. Fractured ribs Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic alcoholism							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 7-12-97		28b. Time of Injury unknown		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred Fell at work		28e. Location (Street and Number or Rural Route Number, City or Town, State) 5055 North point Sparrows Point, Maryland					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 21, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature 			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22133

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harvey L Emerick				2. Date of Death Month 07 Day 19 Year 97		3. Time of Death 4:45pm		
	4a. Facility Name (If not Institution, give street and number) Manor Care - Rossville				4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 177-03-5128		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) March 21, 1915		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Rosedale		
Usual Residence of Decedent		10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 2 Manger Court		10f. Zip Code 21237		10g. Citizen of What Country? USA	
11. Marital Status 3 Widowed 2 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 yr College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Estimator		16b. Kind of Business/Industry Transportation					
17. Father's Name (First, Middle, Last) Charles Emerick				18. Mother's Name (First, Middle, Maiden Surname) Susan Lee					
19a. Informant's Name/Relationship (Type, Print) Ruth Randy				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6815 East Baltimore Street Baltimore MD. 21224					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 7/22/97 Rossville Md.		20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee R. Terry Connolly		22. Name and Address of Facility Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. End stage coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Non-insulin dependent diabetes mellitus				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
				24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier L. Pfeiffer		29c. License number D35410		29d. Date signed (Month, Day, Year) July 21, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lisa Pfeiffer 6918 Ridge Rd. Balto, MD 21237									
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature Judith Davidson-Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

T

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22134

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eleanor Jane Fellers		2. Date of Death Month July Day 19 Year 1997		3. Time of Death 8:25 AM
	4a. Facility Name (If not institution, give street and number) Heritage Nursing Home		4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 232-26-6557	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Nov 15 1918		9. Birthplace (State or Foreign Country) West Virginia		
Usual Residence of Decedent					
10a. State MD		10b. County Baltimore		10c. City, Town or Location Dundalk	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 8146 Midhaven Road		10f. Zip Code 21222		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) George Ambrose		18. Mother's Name (First, Middle, Maiden Surname) Mary Jane Frederick			
19a. Informant's Name/Relationship (Type, Print) Edgar R. Fellers, Jr./son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8146 Midhaven Road Dundalk, MD 21222			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. Location - City or Town, State 7/22/97 Baltimore, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. CARCINOMA OF LUNG WITH METASTASIS Unknown					
Due to (or as a consequence of):					
b. MALIGNANT PLEURAL EFFUSION Unknown					
Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Parinder K. Telle		29c. License number D27188		29d. Date signed (Month, Day, Year) 7/21/97	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parinder K. Telle 2 Market Place Baltimore MD 21222					
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature John Davidson-Randell			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

2

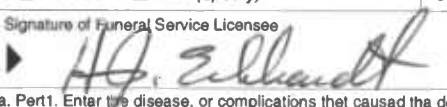
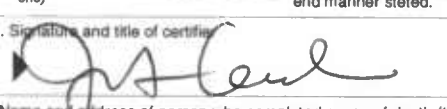

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22135

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred R. Forwood				2. Date of Death Month Day Year July 18, 1997		3. Time of Death 9:30 a.m.	
	4a. Facility Name (If not institution, give street and number) Manor Care Health Services				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-07-2281	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 30, 1918	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore	10c. City, Town or Location Lutherville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1708 Broadway Road			10f. Zip Code 21093		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Homemaker			
	17. Father's Name (First, Middle, Last) Joseph Harold Scott				18. Mother's Name (First, Middle, Maiden Surname) Olive Mabel Robinson			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Kathleen Bohn				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Hebron Dr., Baltimore, Md. 21220			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carrolls Chapel Cem. July 21, 1997 Lutherville, Md.		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117					
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCENDING AORTA Due to (or as a consequence of): hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 15 yr 1 yr							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 		29c. License number D-12550		29d. Date signed (Month, Day, Year) 7/17/97			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JAMES QUINLAN, MD 7801 YORK RD Towson Md 21204							
State Registrar	31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

T

Page 1 of 1

Page 1 of 1

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting cycle, from identifying the transaction to posting it to the appropriate ledger account.

3. The third part of the document discusses the role of the auditor in verifying the accuracy of the records. It explains how the auditor uses various techniques, such as sampling and vouching, to ensure that the financial statements are true and fair.

4. The fourth part of the document discusses the importance of internal controls in preventing errors and fraud. It describes the various types of controls, such as segregation of duties and authorization requirements, and how they are implemented in the organization.

5. The fifth part of the document discusses the role of the management in ensuring the accuracy of the financial statements. It explains how management is responsible for the overall integrity of the financial system and for the accuracy of the information provided to the shareholders.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22136

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George FOLKS				2. Date of Death Month Day Year July 18, 1997		3. Time of Death 5:25 P.M.	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-03-5483	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 20, 1915		9. Birthplace (State or Foreign Country) Baltimore, Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Baltimore County			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 4213 Cardwell Avenue			10f. Zip Code 21236		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry City Hospital			
	17. Father's Name (First, Middle, Last) George Folks				18. Mother's Name (First, Middle, Maiden Surname) Lula Estelle Carter			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lula Raines (Niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4213 Cardwell Avenue Baltimore, Maryland 21236			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery		Date July 23, 1997		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Probable cardiac arrhythmia with resulting hypoxemia Due to (or as a consequence of): b. Probable sepsis Due to (or as a consequence of): c. Pulmonary edema Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 4 days 6 days 4 days
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number RD 01926		29d. Date signed (Month, Day, Year) July 18, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Kim 9000 Franklin Square Dr. Baltimore, Maryland 21237								
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

05105

T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD

2. Date of Death

Month

Day

Year

3. Time of Death

4-50P.M.

GARNETT

4a. Facility Name (If not institution, give street and number)

KESWICK MULTI-CARE CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

250 09 6005

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

AUG. 22. 1916 SOUTH CAROLINA

Usual Residence of Decedent

10e. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4400 BELVIEU AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S. OF A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

FRED GARNETT

18. Mother's Name (First, Middle, Maiden Surname)

LUCINDA SHINE

19a. Informant's Name/Relationship (Type, Print)

MARY V. GARNETT (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4400 BELVIEU AVENUE BALTIMORE, MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD. NAT. MEM. PARK 7/25/97

Date

20c. Location - City or Town, State

LAUREL, MD. P.G. CO.

21. Signature of Funeral Service Licensee

Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 21215-6393

4517 PARK HEIGHTS AVE. BALTO, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.

Immediate Cause (Final disease or condition resulting in death)

e. HEPATOCELLULAR CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

DEMENCIA (PRELIM) ALZHEIMERS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles Davidson MD

29c. License number

12399

29d. Date signed (Month, Day, Year)

JULY 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CHARLES DAVIDSON MD, MD KESWICK 700 W. 40th St Baltimore, MD 21211

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22138

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <div align="center" style="font-size: 1.2em;">Stanley Florian Glanville</div>				2. Date of Death Month Day Year <div align="center" style="font-size: 1.2em;">JULY 20 1997</div>		3. Time of Death <div align="center" style="font-size: 1.2em;">8:15 am</div>	
	4a. Facility Name (If not institution, give street and number) <div align="center" style="font-size: 1.2em;">Frederick Villa Nursing Center</div>				4b. City, Town, or Location of Death <div align="center" style="font-size: 1.2em;">Catonsville</div>		4c. County of Death <div align="center" style="font-size: 1.2em;">Baltimore</div>	
Funeral Director	5. Social Security Number <div align="center" style="font-size: 1.2em;">217-09-2155</div>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <div align="center" style="font-size: 1.2em;">80</div> Yrs.		8. Date of Birth (Month, Day, Year) <div align="center" style="font-size: 1.2em;">DEC 21, 1916</div>	
	9. Birthplace (State or Foreign Country) <div align="center" style="font-size: 1.2em;">Maryland</div>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <div align="center" style="font-size: 1.2em;">MD</div>		10b. County <div align="center" style="font-size: 1.2em;">Anne Arundel</div>		10c. City, Town or Location <div align="center" style="font-size: 1.2em;">Pasadena</div>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <div align="center" style="font-size: 1.2em;">608 Laurel Drive</div>				10f. Zip Code <div align="center" style="font-size: 1.2em;">21122</div>		10g. Citizen of What Country? <div align="center" style="font-size: 1.2em;">USA</div>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <div align="center" style="font-size: 1.2em;">WW II</div>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <div align="center" style="font-size: 1.2em;">White</div>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <div align="center" style="font-size: 1.2em;">12</div> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <div align="center" style="font-size: 1.2em;">Deputy US Marshall</div>		16b. Kind of Business/Industry <div align="center" style="font-size: 1.2em;">Federal Government</div>	
	17. Father's Name (First, Middle, Last) <div align="center" style="font-size: 1.2em;">James William Glanville</div>				18. Mother's Name (First, Middle, Maiden Surname) <div align="center" style="font-size: 1.2em;">Gertrude May DeGraft</div>			
	19a. Informant's Name/Relationship (Type, Print) <div align="center" style="font-size: 1.2em;">Frances C. Sturgeon/daughter</div>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <div align="center" style="font-size: 1.2em;">608 Laurel Dr. Pasadena, MD 21122</div>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <div align="center" style="font-size: 1.2em;">Crestlawn Memorial Gardens</div>		20c. Date <div align="center" style="font-size: 1.2em;">7/23/97</div>		20d. Location - City or Town, State <div align="center" style="font-size: 1.2em;">Marriottsville, MD</div>	
	21. Signature of Funeral Service Licensee <div align="center" style="font-size: 1.2em;">Edward A. Gregorchik</div>				22. Name and Address of Facility <div align="center" style="font-size: 1.2em;">MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228</div>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <div align="center" style="font-size: 1.2em;">Alzheimers Disease</div> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 10%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <div align="center" style="font-size: 1.2em;">M</div>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <div align="center" style="font-size: 1.2em;">Raymond Miller MD</div>				29c. License number <div align="center" style="font-size: 1.2em;">D47683</div>		29d. Date signed (Month, Day, Year) <div align="center" style="font-size: 1.2em;">7/21/97</div>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <div align="center" style="font-size: 1.2em;">Raymond Miller 25 Main Street, Reisterstown MD 21136</div>								
31. Date filed (Month, Day, Year) <div align="center" style="font-size: 1.2em;">JUL 22 1997</div>				32. Registrar's Signature <div align="center" style="font-size: 1.2em;">Julia Davidson-Rodriguez</div>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

**State
Registrar**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22139

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth A. Gross				2. Date of Death Month Day Year July 18, 1997				3. Time of Death 8 P.M.	
	4a. Facility Name (If not institution, give street and number) 52 Glen Ridge Road, Apartment B-4				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 215-01-7337		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 15, 1916		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 52 Glen Ridge Road, Apartment B-4				10f. Zip Code 21061		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) waitress				16b. Kind of Business/Industry restaurant			
	17. Father's Name (First, Middle, Last) Martin F. Juister				18. Mother's Name (First, Middle, Maiden Surname) Lillian E. Thompson					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Peggy Ann Bourque / niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52 Glen Ridge Road Glen Burnie MD 21061					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Western Cemetery		Date July 21 1997		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee Alan C. ...				22. Name and Address of Facility McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ADVANCED PANCREATIC CANCER 3/18/97 Due to (or as a consequence of): b. ATMEL RESECTION 5/97 Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Dr. PATEL				29c. License number D 37111		29d. Date signed (Month, Day, Year) 7/21/97			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 606 H M M O N D S LANE, BALTIMORE, MD 21225 R. PATEL									
Physician /Medical Examiner	31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature John Davidson-Randall							
	12									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22140

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES GETTY

2. Date of Death

Month

Day

Year

JULY

14

1997

3. Time of Death

6:52 PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

208-76-1207

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs. 21

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JUNE 23, 1997

9. Birthplace (State or Foreign Country)

Hershey Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

York

10c. City, Town or Location

York

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2633 N. Sherman St.

10f. Zip Code

17402

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Zero

College (1-4 or 5+)

child

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

child

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

Charles L. Getty

18. Mother's Name (First, Middle, Maiden Surname)

Theresa M. Lehr

19a. Informant's Name/Relationship (Type, Print)

Charles L. Getty

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2633 N. Sherman St. York PA 17402

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Rose Cemetery

Date

7-18-97

20c. Location - City or Town, State

York, PA

21. Signature of Funeral Service Licensee

George J. Cuilla

22. Name and Address of Facility

John W. Keffer Funeral Home Inc.

902 Mt. Rose Ave. York PA 17403

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGENITAL HEART DISEASE

Due to (or as a consequence of):

21 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OCCIPITAL HEMORRHAGE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Peter J. Molyneux MD

29c. License number

D45651

29d. Date signed (Month, Day, Year)

JULY 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER J. MOLYNEUX JR. THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

041

1. The first part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation

$$f(x) = \sum_{n=0}^{\infty} \frac{a_n}{n!} x^n$$

where a_n are the coefficients of the power series. It is shown that the function $f(x)$ is analytic in the region $|x| < R$ where R is the radius of convergence of the series.

2. In the second part of the paper, the function $f(x)$ is studied in more detail. It is shown that the function $f(x)$ is bounded in the region $|x| < R$ and that it has a unique continuation property.

3. The third part of the paper is devoted to the study of the properties of the function $f(x)$ in the region $|x| > R$. It is shown that the function $f(x)$ is unbounded in this region and that it has a unique continuation property.

4. The fourth part of the paper is devoted to the study of the properties of the function $f(x)$ in the region $|x| = R$. It is shown that the function $f(x)$ is bounded in this region and that it has a unique continuation property.

5. The fifth part of the paper is devoted to the study of the properties of the function $f(x)$ in the region $|x| < R$ and $|x| > R$. It is shown that the function $f(x)$ is bounded in the region $|x| < R$ and unbounded in the region $|x| > R$.

6. The sixth part of the paper is devoted to the study of the properties of the function $f(x)$ in the region $|x| < R$ and $|x| > R$. It is shown that the function $f(x)$ is bounded in the region $|x| < R$ and unbounded in the region $|x| > R$.

7. The seventh part of the paper is devoted to the study of the properties of the function $f(x)$ in the region $|x| < R$ and $|x| > R$. It is shown that the function $f(x)$ is bounded in the region $|x| < R$ and unbounded in the region $|x| > R$.

8. The eighth part of the paper is devoted to the study of the properties of the function $f(x)$ in the region $|x| < R$ and $|x| > R$. It is shown that the function $f(x)$ is bounded in the region $|x| < R$ and unbounded in the region $|x| > R$.

9. The ninth part of the paper is devoted to the study of the properties of the function $f(x)$ in the region $|x| < R$ and $|x| > R$. It is shown that the function $f(x)$ is bounded in the region $|x| < R$ and unbounded in the region $|x| > R$.

10. The tenth part of the paper is devoted to the study of the properties of the function $f(x)$ in the region $|x| < R$ and $|x| > R$. It is shown that the function $f(x)$ is bounded in the region $|x| < R$ and unbounded in the region $|x| > R$.

MAJOR F. HARRIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22141

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) MAJOR F. HARRIS				2. Date of Death Month JULY Day 17 Year 1997		3. Time of Death 3:50 AM	
4a. Facility Name (If not institution, give street and number) 501 DOLPHIN STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 228-32-9181		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAR. 2 1917	9. Birthplace (State or Foreign Country) VIRGINIA
Usual Residence of Decedent							
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 501 DOLPHIN STREET APT 1115				10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 41/45		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE		16b. Kind of Business/Industry HEALTH	
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) MARGARETT JACKS			
19a. Informant's Name/Relationship (Type, Print) Naomi Harris/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Dolphin Street, Apt 1115 Baltimore Maryland 21217			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VETERANS		20c. Location - City or Town, State 7-25 OWINGS MILLS, MARYLAND			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? partial <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Dennis J. Chute, MD				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 17, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature <i>[Signature]</i>			

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22142

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

RUTH LOUISE HARRIS

2. Date of Death
Month Day Year

JULY 18, 1997

3. Time of Death

2:58 p

4a. Facility Name (If not institution, give street and number)

6626 VINCENT LANE apt. 102

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

5. Social Security Number

169-22-1525

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

OCT. 12, 1903

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6626 VINCENT LANE

10f. Zip Code

21215

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 th

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

EASTERN SHORE

TEMPLE HILLS-Resort

17. Father's Name (First, Middle, Last)

JOSEPH EVANS

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA JONES

19a. Informant's Name/Relationship (Type, Print)

MARTHA WAGNER- DAUG.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6626 VINCENT LANE, BALTIMORE, MD 21215

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE NATIONAL CEM. 7-22-97 BALTO., MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WM. C. MARCH FH.-4300 WABASH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. COLON CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

1 1/2 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

McNeil Brockington MD, Liberty High, Balto. MD

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

571

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#20b PER F.H. FLM#G749 7/22/98 J.A. **Certificate of Death**

Reg. No.

97 22143

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE

2. Date of Death

Month
JULYDay
18Year
1997

3. Time of Death

7:12 AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MED CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

—

Funeral
Director

5. Social Security Number

213-64-5260

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

41

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 17, 1956

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

None

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

2612 N. Calvert St.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Scaffold Builder

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

George Harrison Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Peaker

19a. Informant's Name/Relationship (Type, Print)

Johnna Harrison / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2612 Calvert St. Baltimore, Maryland 21218

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

7/23/97

20c. Location - City or Town, State

Landsdowne, Maryland

21. Signature of Funeral Service Licensee

Ronald A. Grayson

22. Name and Address of Facility

The Derrick C. Jones Funeral Home

4611 Park Heights Ave. Baltimore, Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DISSEMINATED MYCOBACTERIUM AVIUM INTRACELLULARE

Due to (or as a consequence of):

b. HUMAN IMMUNO DEFICIENCY VIRUS INFECTION

Due to (or as a consequence of):

c. (A I D S - END STAGE)

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CYTOMEGALOVIRUS INFECTION

ANEMIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patrick A. Murphy

29c. License number

D 13688

29d. Date signed (Month, Day, Year)

07/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICK A. MURPHY

8 SCOTTSDALE COURT LUTHERVILLE MD 21093

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Harrison-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitTo Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Lena

Hutchins

2. Date of Death

Month
July

Day

Year

19, 1997

3. Time of Death

10:50 pm

4a. Facility Name (If not institution, give street and number)

Manor Care Health Services-Towson

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore Co.

5. Social Security Number

217-05-2110

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
October 6, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1823 Wildwood Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Insurance Company

17. Father's Name (First, Middle, Last)

John

Gianotti

18. Mother's Name (First, Middle, Maiden Summa)

Josephine

Boggio

19a. Informant's Name/Relationship (Type, Print)

Mr. James C. Hutchins/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

242 North Street Millersburg, PA. 17061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corporation

Date

7/21/97

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Brian A. Willem

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a.

C.O.P.D

Due to (or as a consequence of):

b.

A.S.C.V.D

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

> 1 year

> 5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 osler drive

AYMAN FATHI AKKAD

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22145

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA

HERGET

2. Date of Death

Month

Day

Year

JULY 20, 1997

3. Time of Death

5:23 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-40-5897

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

10/17/1898

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

800 Southerly Rd., Edenwald

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Edward C. Herget

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Trutschell

19a. Informant's Name/Relationship (Type, Print)

Lorena H. Allers (friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2117 Eastham Rd. Timonium, Md. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery

Date

7/24/97

20c. Location - City or Town, State

Parkville, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

SEPSIS

e.

Due to (or as a consequence of):

PROBABLE ACUTE DIVERTICULITIS

b.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

24 HOURS

24 HOURS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION

CHRONIC OBSTRUCTIVE LUNG DISEASE

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 16492

29d. Date signed (Month, Day, Year)

July 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BEATRIZ P. DIZON, M.D.

7620 YORK ROAD

TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

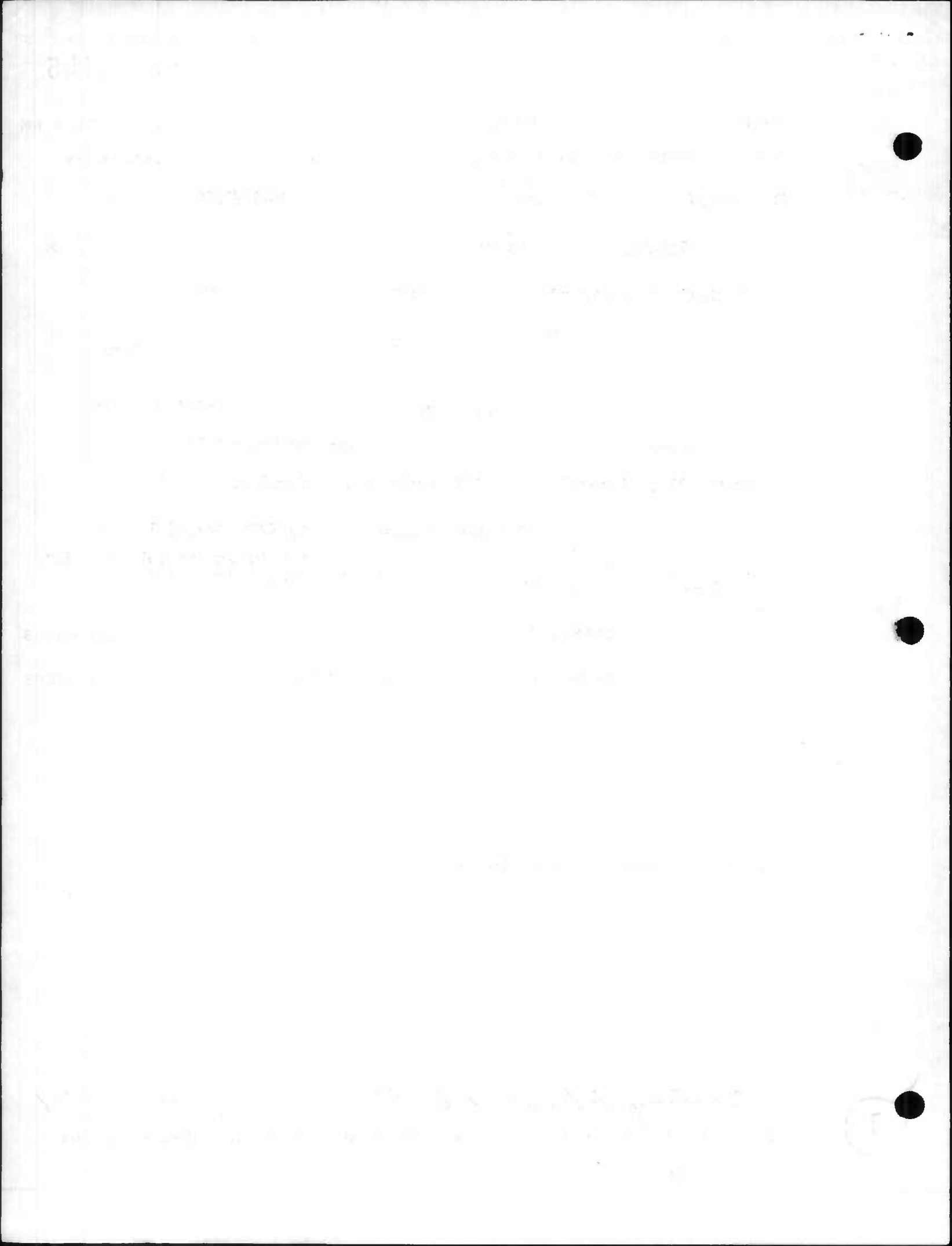
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

T



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22146

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD

2. Date of Death

Month JULY Day 12 Year 1997

3. Time of Death

5:35 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HARBOR

HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-52-1011

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month 10 Day 10 Year 48

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

608 BAKER STREET

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFR. AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER'S AID

16b. Kind of Business/Industry

BALTO. PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

HOWARD L. HASKINS

18. Mother's Name (First, Middle, Maiden Surname)

LILLIE HASKINS

19a. Informant's Name/Relationship (Type, Print)

LILLIE HASKINS (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2928 CHERRYLAND RD. BALTO. MD 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KINGS MEM. PARK

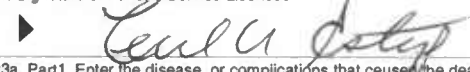
Date

7/18/97

20c. Location - City or Town, State

RANDALLSTOWN MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTO. MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LARGE and small Bowel Ischemia and

Due to (or as a consequence of):

b. Intestinal Obstruction and Adhesion

Due to (or as a consequence of):

c. Peritonitis and Liver Cirrhosis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 days

7 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

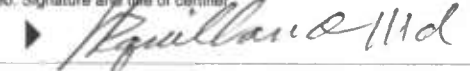
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying PhysicianTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier



29c. License number

D28988

29d. Date signed (Month, Day, Year)

July 14, 1997

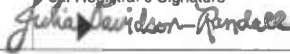
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Line R. Arguillano Md. 3001 South Hanover St. Balt. MD 21226

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22147**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Peter Holeywinski				2. Date of Death Month Day Year July 19 1997		3. Time of Death 2:05 AM	
	4a. Facility Name (If not institution, give street and number) 6817 Brentwood Ave.				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-07-5471		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) May 22 1920	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
Usual Residence of Decedent								
10a. State Maryland			10b. County Baltimore			10c. City, Town or Location Dundalk		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number 6817 Brentwood Ave.			10f. Zip Code 21222		
10g. Citizen of What Country? USA			11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WW II		
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) Collage (1-4or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Forklift Operator			16b. Kind of Business/Industry Brewery			17. Father's Name (First, Middle, Last) Andrew Holeywinski		
18. Mother's Name (First, Middle, Maiden Surname) Anna Rosel			19a. Informant's Name/Relationship (Type, Print) Helen C. Holeywinski/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6817 Brentwood Ave. Dundalk, MD 21222		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.			20c. Location - City or Town, State 7/21/97 Towson, MD		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day Year)								
28b. Time of Injury M								
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 								
29c. License number D24149								
29d. Date signed (Month, Day, Year) 7/20/97								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dorothy A. Snow 10 N. Greene St Balt MD 21201								
31. Date filed (Month, Day, Year) JUL 22 1997								
32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22148

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DIANE CAROL HORSEMAN

2. Date of Death

Month Day Year
JULY 18, 1997

3. Time of Death

5:45 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3621 DORSHIRE COURT

4b. City, Town, or Location of Death

PASADENA

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

218-36-8044

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 9, 1939

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

PASADENA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3621 DORSHIRE COURT

10f. Zip Code

21122

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ NoIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LOBBY RECEPTIONIST

16b. Kind of Business/Industry

BALTIMORE

GAS AND ELECTRIC

17. Father's Name (First, Middle, Last)

ERNEST COX

18. Mother's Name (First, Middle, Maiden Surname)

LILLIAN DOLORES SCHELHAUSE

19a. Informant's Name/Relationship (Type, Print)

ROBERT L. HORSEMAN/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3621 DORSHIRE COURT PASADENA, MARYLAND 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

JULY 21,

1997

20c. Location - City or Town, State

GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MCCULLY-POLYNIAK FUNERAL HOME

3204 MOUNTAIN ROAD PASADENA, MARYLAND 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic breast Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

7 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18587

29d. Date signed (Month, Day, Year)

JULY 20 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL GORMLEY 900 CATON AVE

BALTIMORE MD

21229

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

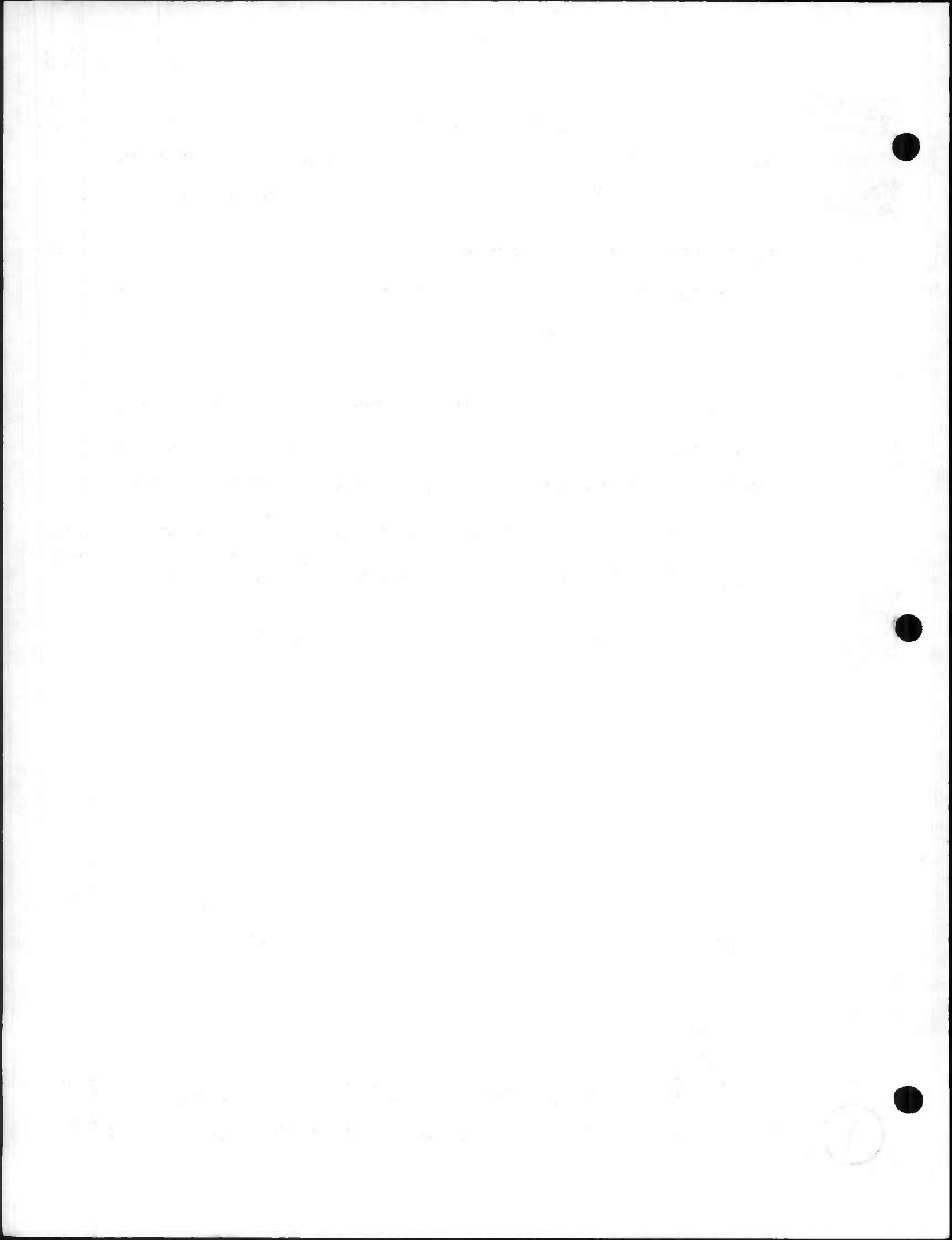
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 22149

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Agnes Hazard				2. Date of Death Month Day Year July 16, 1997		3. Time of Death 1:30 PM	
	4a. Facility Name (If not institution, give street and number) 162 Fairhaven Road				4b. City, Town, or Location of Death Tracy's Landing		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 220-78-6054		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 11, 1911	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Tracy's Landing		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 162 Fairhaven Road				10f. Zip Code 20779		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Co-Owner/Manager		16b. Kind of Business/Industry Paint			
	17. Father's Name (First, Middle, Last) Gustav Carl Heinrich				18. Mother's Name (First, Middle, Maiden Surname) Agnes Wilde			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Norman T. Hazard, Jr./son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20779 160 Fairhaven Road, Tracy's Landing, MD			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Cemetery		Data 7/18/97		20c. Location - City or Town, State Davidsonville, MD	
	21. Signature of Funeral Service Licensee <i>Batist J. Smith</i>				22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Avenue, Annapolis, MD 21401			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiac Arrhythmia</i> Due to (or as a consequence of): b. <i>Coronary Atherosclerosis</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Jon B. Lowe, MD</i>				29c. License number 1718529		29d. Date signed (Month, Day, Year) 07-19-97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jon B. Lowe, MD, 2007 Tidewater Colonies Dr, #214, Annapolis, MD 21401								
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature <i>Julia Davidson-Randall</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

T

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22150

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SWANSON

IVEY

2. Date of Death

Month
JULYDay
15Year
1997

3. Time of Death

17:31

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral
Director

5. Social Security Number

238-64-9442

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/21/1941

9. Birthplace (State or Foreign Country)

N. CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

1 Yes 2 No
XX

10e. Street and Number

10919 HARMEL DRIVE

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 X Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
if Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 Yes 2 X No
Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ENGINEERING MANAGER

16b. Kind of Business/Industry

ALLIED SIGNAL

17. Father's Name (First, Middle, Last)

ERNEST IVEY

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE WILKINS

19a. Informant's Name/Relationship (Type, Print)

VERONICA IVEY (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10919 HARMEL DRIVE, COLUMBIA, MD 21044

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHRIST EPISCOPAL CEM.

Date

7/19/97

20c. Location - City or Town, State

COLUMBIA, MD

21. Signature of Funeral Service Licensee

R. G. Witke

22. Name and Address of Facility

WITZKE FUNERAL HOME, INC.

5555 TWIN KNOLLS ROAD, COLUMBIA, MD 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

ADULT RESPIRATORY DISTRESS SYNDROME

Approximate
Interval Between
Onset and Death

TWO WEEKS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE LIVER FAILURE

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 X No

25. Was case referred to medical
examiner?
1 Yes 2 X No

Hospital:

1 X Inpatient

2 ER/Outpatient

3 DOA

Other:

26. Place of Death (Check only one)

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
2 Accident investigation
3 Suicide 6 Could not be
4 Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Greg Powell MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREG POWELL 600 NORTH WOLFE STREET JOHNS HOPKINS HOSPITAL BALTIMORE 21287

31. Date filed (Month, Day, Year)

JUL 22 1997

2. Registrar's Signature
John Davidson-RandallState
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22151

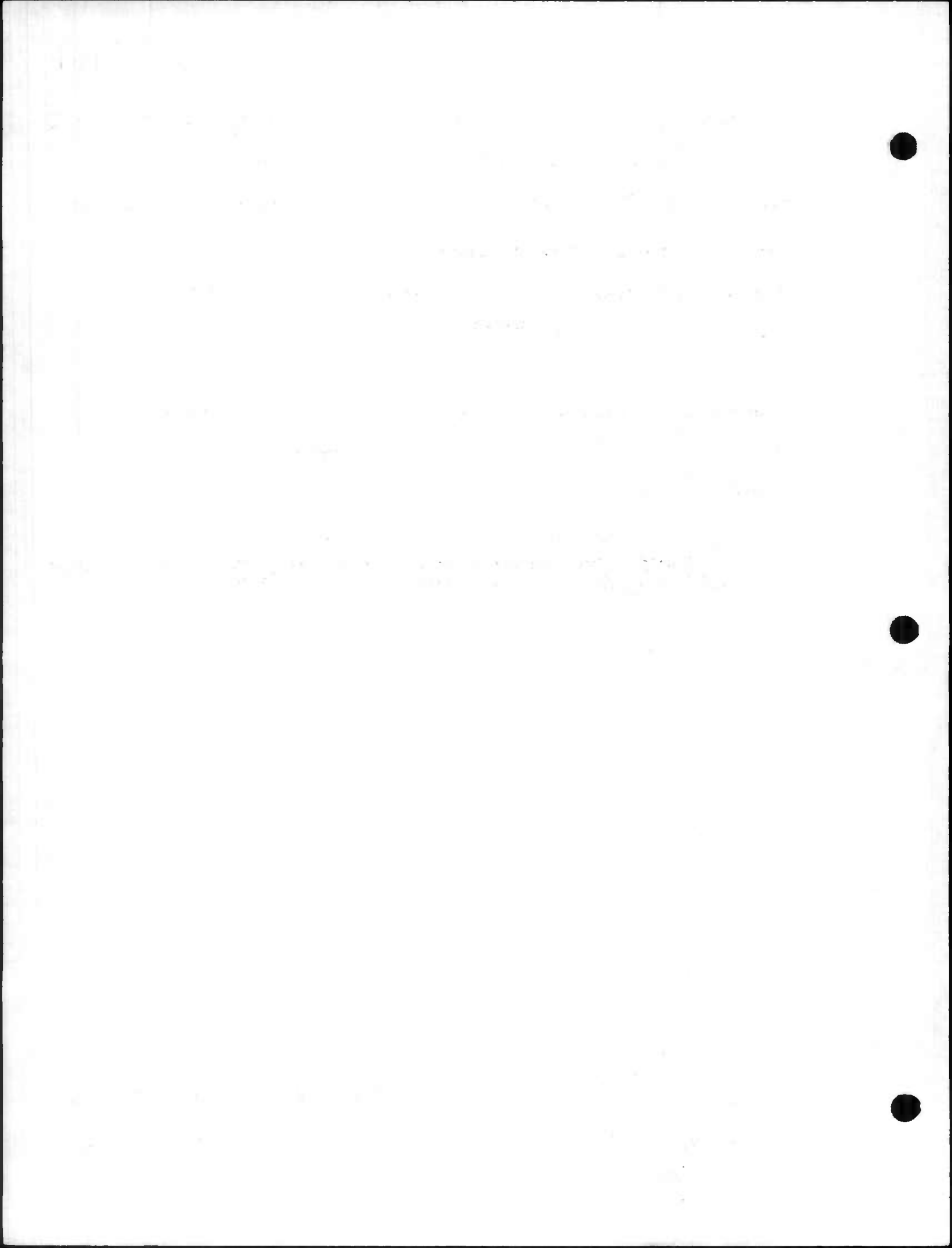
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLIFFORD JARRETT				2. Date of Death Month July Day 15 Year 1997		3. Time of Death 4:00	
	4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death CITY	
Funeral Director	5. Social Security Number unknown	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 1, 1931		9. Birthplace (State or Foreign Country) unknown
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore City		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1708 West North Avenue				10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown Collage (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown			16b. Kind of Business/Industry unknown	
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown				
19a. Informant's Name/Relationship (Type, Print) unknown				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place) in state		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director 7/18/97				22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. ARDS Due to (or as a consequence of): c. DRUG ABUSE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL INSUFFICIENCY - SEIZURES MALNUTRITION - ELECTROLYTIC IMBALANCE - METABOLIC ACIDOSIS						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature] MD		29c. License number D19086		29d. Date signed (Month, Day, Year) July 15, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REBECCO E. CORREY LIBERTY MEDICAL CENTER								
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22152

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

OTIS E. JONES

2. Date of Death

Month Day Year
JULY 18 1997

3. Time of Death

12:05 A.M.

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-30-0789

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG 25, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1616 Mountmor Court

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Taxi Service

17. Father's Name (First, Middle, Last)

Charles Jones

18. Mother's Name (First, Middle, Maiden Surname)

Beulah Mae Riddick

19a. Informant's Name/Relationship (Type, Print)

Bryant D. Jones, Sr./son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2710 Beryl Ave. Baltimore, MD 21205

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 7/18/97 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

None

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W.A. Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

July 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley, MD. GGBMC 6701 N. Charles St. Balto. MD 2120X

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22153

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Janet E. Jeffrey

2. Date of Death

Month
JulyDay
20Year
97

3. Time of Death

5:10 PM

4a. Facility Name (If not Institution, give street and number)

Keswick Multicare Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-68-6631

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

FEB 19

1909

9. Birthplace (State or Foreign Country)

Guyana

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2 Lindsay Lane

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Private Home

17. Father's Name (First, Middle, Last)

UNK.

18. Mother's Name (First, Middle, Maiden Surname)

UNK.

19a. Informant's Name/Relationship (Type, Print)

F. Barton Harvey, Jr./employer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Lindsay Ln. Baltimore, MD 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 7/21/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MULTIPLE CEREBRAL INFARCTS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles Davidson MD

29c. License number

J 12359

29d. Date signed (Month, Day, Year)

July 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles Davidson MD Keswick 700 W. 40th St. Baltimore, MD 21211

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22154**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HENRY Johnson				2. Date of Death Month June Day 28 Year 1997		3. Time of Death 2:45 pm			
	4a. Facility Name (If not institution, give street and number) Greenspring Nursing & Rehab. Center				4b. City, Town, or Location of Death Baltimore, MD		4c. County of Death Baltimore City			
Funeral Director	5. Social Security Number 219-70-3953		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 3, 1923			
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore City		10c. City, Town or Location Baltimore			
Usual Residence of Decedent										
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number 4615 Park Heights Avenue			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown			16b. Kind of Business/Industry unknown				
17. Father's Name (First, Middle, Last) unknown					18. Mother's Name (First, Middle, Maiden Surname) unknown					
19a. Informant's Name/Relationship (Type, Print) unknown					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state					20b. Place of Disposition (Name of cemetery, crematory or other place) unknown		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director					22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) Carcinoma of Esophagus									6 months	
Due to (or as a consequence of): Chronic obstructive pulmonary disease										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Due to (or as a consequence of):										
Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Ramesh Sahasrabudhe					29c. License number D3064		29d. Date signed (Month, Day, Year) 7/6/97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RAMESH SABARATHAN MD Suite 308 521 N. Eotan St Baltimore MD 21201										
31. Date filed (Month, Day, Year) JUL 22 1997			32. Registrar's Signature Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22155

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD JOHNSON				2. Date of Death Month JULY Day 7 Year 1997		3. Time of Death 1146 AM	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death CITY	
Funeral Director	5. Social Security Number 217-54-4430		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 49 Yrs.		8. Date of Birth (Month, Day, Year) MAY 15, 1948	
	9. Birthplace (State or Foreign Country) BALTIMORE, MD.							
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 510 ROSE HILL TERRACE				10f. Zip Code 21218		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFRO AMERICAN	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BROADWAY SERVICES INC.		16b. Kind of Business/Industry HOUSEKEEPER			
	17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) BESSIE JOHNSON			
	19a. Informant's Name/Relationship (Type; Print) DARLENE JOHNSON WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 ROSE HILL TERRACE, BALTIMORE, MARYLAND 21218			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		Date 7/21/97		20c. Location - City or Town, State LANSDOWN, MARYLAND	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		a. CEREBRAL HEMORRHAGE Due to (or as a consequence of):				Approximate Interval Between Onset and Death 10 HRS	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. CEREBROVASCULAR ACCIDENT / HEMORRHAGE Due to (or as a consequence of):				24 HRS	
			c. HYPERTENSION Due to (or as a consequence of):				10 YRS	
			d.					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier COOK, JESON H MD		29c. License number AL4170435 CB402		29d. Date signed (Month, Day, Year) 7/17/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 112 WEST OSTEAD AVE. BALTIMORE, MD 21230 (COOK, JESON H MD)								
State Registrar	31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Received of the Treasurer of the County of ...

the sum of ...

for ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

(T)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22156

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELSIE JAMES

2. Date of Death

July 15 1997

3. Time of Death

5:20 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214 54 7767

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/2/53

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2823 DENHAM CIR.

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify: AFRO
AMERICAN

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

RASSIE WHITE

18. Mother's Name (First, Middle, Maiden Surname)

ROBENA WHITE

19a. Informant's Name/Relationship (Type, Print)

RALPH WHITE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2427 HURON ST, BALTO. MD. 21230

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. ZION CEM.

Date

7/19/97

20c. Location - City or Town, State

LANSDOWNE, MD.

21. Signature of Funeral Service Licensee

Lloyd M. Estep

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTO. MD. 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. END STAGE AIDS
Due to (or as a consequence of):b. SEPSIS
Due to (or as a consequence of):c. PCP PNEUMONIA
Due to (or as a consequence of):d. hypokalemia
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Terence L. Lamb MD

29c. License number

D37203

29d. Date signed (Month, Day, Year)

July 15th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Liberty Medical Center Baltimore MD 21215

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Pandella

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22157

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Francis JONES		2. Date of Death Month July Day 20 Year 1997		3. Time of Death 7:20 pm.	
4a. Facility Name (If not institution, give street and number) FRanklin Square Hospital Center			4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
5. Social Security Number 213-01-3525	6. Sex 15 M 2 F	7. Age (in yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth Sept. 9, 1911
9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent					
10a. State Md.	10b. County Baltimore	10c. City, Town or Location Essex		10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 1008 Essex Ave.			10f. Zip Code 21221		10g. Citizen of What Country? USA
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) 8th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk	
16b. Kind of Business/Industry Anchor Post		17. Father's Name (First, Middle, Last) John T. Jones		18. Mother's Name (First, Middle, Maiden Surname) Anna Sigrist	
19a. Informant's Name/Relationship (Type, Print) Edward Jones / nephew			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12609 Falls Road Cockeysville Md. 21030		
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer Cemetery		20c. Location - City or Town, State Baltimore MD.	
21. Signature of Funeral Service Licensee R. Terry Connelly		22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
e. Hypoxemia Due to (or as a consequence of):					
b. Metastatic Lung Cancer Due to (or as a consequence of):					
c. Angiosarcoma of Liver Due to (or as a consequence of):					
d.					
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
24a. Was an autopsy performed? 1 Yes 2 No					
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
25. Was case referred to medical examiner? 1 Yes 2 No					
26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year) 7/23/97		28b. Time of Injury M	
28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 Medical Examiner					
29b. Signature and title of certifier John Kim MD					
29c. License number RD1917					
29d. Date signed (Month, Day, Year) July 20, 1997					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Kim MD 9000 Franklin Square Drive, Baltimore, Maryland 21237					
31. Date filed (Month, Day, Year) JUL 22 1997					
32. Registrar's Signature Julia Davidson-Rendell					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

1. The first part of the document discusses the importance of maintaining accurate records of all transactions, including sales, purchases, and expenses. It emphasizes the need for a systematic approach to record-keeping, such as using a ledger or accounting software, to ensure that all data is properly captured and organized.

2. The second part of the document focuses on the analysis of financial data. It describes various methods for interpreting the recorded information, such as calculating profit margins, identifying trends, and comparing performance against industry benchmarks. This analysis is crucial for making informed business decisions and identifying areas for improvement.

3. The third part of the document addresses the legal and regulatory aspects of financial reporting. It outlines the requirements for compliance with applicable laws and regulations, such as the Sarbanes-Oxley Act, and discusses the consequences of non-compliance. It also highlights the importance of transparency and accountability in financial reporting.

4. The fourth part of the document discusses the role of financial reporting in strategic planning and decision-making. It explains how the information derived from financial records can be used to develop long-term business strategies, allocate resources effectively, and monitor progress towards organizational goals.

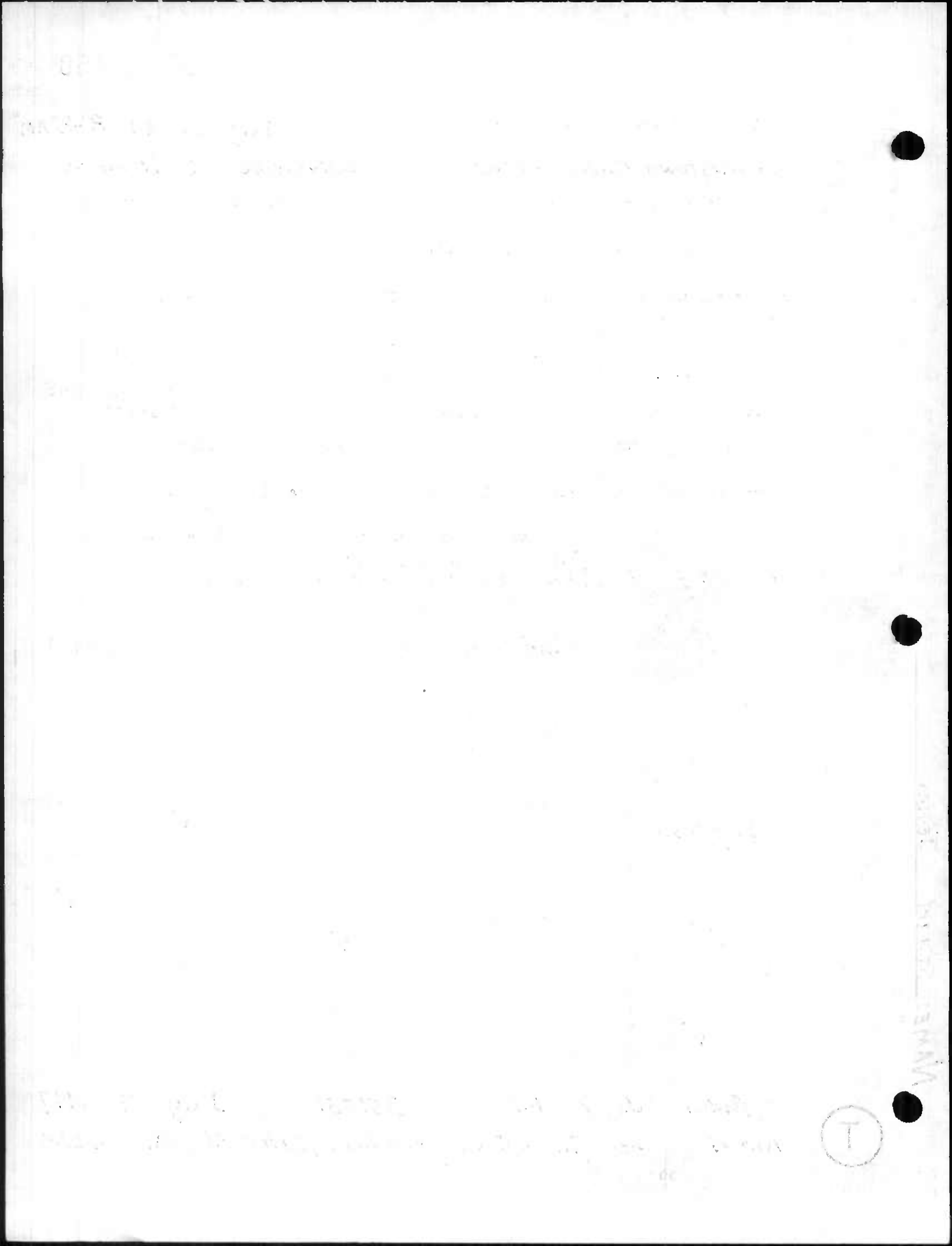
5. The fifth part of the document concludes by emphasizing the overall significance of financial reporting for the success and sustainability of a business. It reiterates the importance of maintaining accurate records, analyzing data thoroughly, and adhering to legal and regulatory requirements.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22158**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) STUART EDWARD JONES Sr.				2. Date of Death Month Day Year July 17 97		3. Time of Death 8:45 AM	
	4a. Facility Name (If not institution, give street and number) Charlestown Care Center				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-03-3204		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) FEB 26 1907	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 701 Maiden Choice Lane 125B-1 North		10f. Zip Code 21228	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Writer			
	16. Kind of Business/Industry National Geographic Magazine				17. Father's Name (First, Middle, Last) Edward JONES			
	18. Mother's Name (First, Middle, Maiden Surname) Anne KRATZ				19a. Informant's Name/Relationship (Type, Print) Stuart E. Jones, Jr. / son			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Rambler Rd, Jamaica Plain, MA 02130				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			
	20b. Place of Disposition (Name of cemetery, crematory or other place) MD VET CEM-Crownsville				20c. Location - City or Town, State Crownsville, MD			
	21. Signature of Funeral Service Licensee Jackie D. Shannon				22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 Wilkens Ave, Baltimore, MD 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End stage Dementia Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death Years			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier Andres Salazar MD				29c. License number D51051				
29d. Date signed (Month, Day, Year) July 17 1997				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228				
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature Julie Davidson-Randall				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22159**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jean Baptiste Kpangni

2. Date of Death

Month Day Year
July 3, 1997

3. Time of Death

3:55am

Funeral
Director

4e. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

217 33 7569

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
02-24-65

9. Birthplace (State or Foreign Country)

IVORY COAST

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8416 12th Avenue

10f. Zip Code

20903

10g. Citizen of What Country?

AFRICA - IVORY COAST

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: AFRICAN

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th +

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

THOMAS KPANGNI

18. Mother's Name (First, Middle, Maiden Surname)

MANSAN AGNES KASSI

19a. Informant's Name/Relationship (Type, Print)

PATRICIA HUSTON KPANGNI

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8416 12th Avenue; Silver Spring, MD 20903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HARMONY MEMORIAL PARK 7/19/97 WEST HYATTSVILLE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. A. Howard #879

22. Name and Address of Facility

Bianchi Funeral Service
420 - H St. N.E. WASH. D.C. 20002

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence of):

b. Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

1019 - 31m

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Kaposi's Sarcoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicida4 ☐ Homicida5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Paul Kretting MD

29c. License number

R21435

29d. Date signed (Month, Day, Year)

July 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Paul Kretting MD 2101 Medical Park Drive Silver Spring

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

T

3

MISSING

DEATH

certificate no.: 97-22160

DEATH

DL-99100

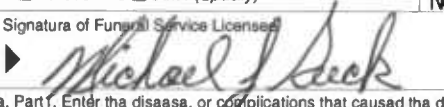

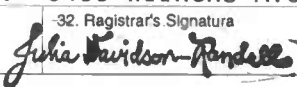
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22161

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Teresa Keeler				2. Date of Death Month July Day 18 Year 1997				3. Time of Death 3:10 PM	
	4a. Facility Name (If not institution, give street and number) St. Martin's Home				4b. City, Town, or Location of Death Catonsville				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 577-52-3996		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) October 17, 1902		9. Birthplace (State or Foreign Country) Illinois	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 601 Maiden Choice Lane				10f. Zip Code 21228				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher & Homemaker				16b. Kind of Business/Industry Education		
17. Father's Name (First, Middle, Last) Patrick Joseph Conway				18. Mother's Name (First, Middle, Maiden Surname) Julia Agnes Kennedy						
19a. Informant's Name/Relationship (Type, Print) William Cardinal Keeler (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Cathedral Street, Room 704, Baltimore, Md. 21201						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		Data 7/23/1997		20c. Location - City or Town, State Baltimore, Maryland				
21. Signature of Funeral Service Licensed 				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Md. 21214						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Pneumonia Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 week										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe aortic stenosis. Broncheictasis of lung Right Stroke. Chronic obstructive lung disease										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) —		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number D18362		29d. Date signed (Month, Day, Year) 7/19/1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Komal K. Dang, M.D. 3455 Wilkens Avenue, Suite 308, Baltimore, Maryland 21229										
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22162

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Bishop Klein				2. Date of Death Month Day Year July 21, 1997		3. Time of Death 12:30 AM	
	4a. Facility Name (If not institution, give street and number) Manor Care Health Services				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-74-4628	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 15, 1906		9. Birthplace (State or Foreign Country) D.C.
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Lutherville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 1013 W. Seminary Avenue				10f. Zip Code 21093		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Red Cross	
17. Father's Name (First, Middle, Last) James Bishop				18. Mother's Name (First, Middle, Maiden Surname) Rose Giebel				
19a. Informant's Name/Relationship (Type, Print) Raymond Klein				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Manor Avenue Baltimore, Maryland 21206				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 7/24/97		20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee Martin J. Dippel				22. Name and Address of Facility The Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Heart Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death years.
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Pancreatic Aneurysm								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier J. Davidson-Randall				29c. License number D08358		29d. Date signed (Month, Day, Year) 7/21/97		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) SPACIO R. PATRICKO 8903 HARTFORD RD BALTIMORE MARYLAND 21224								
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature J. Davidson-Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22163

Certificate of Death

Reg. No.

FRANCINA GRAVES LEWIS

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCINA GRAVES LEWIS

2. Date of Death

Month
JULYDay
13Year
1997

3. Time of Death

10:20 PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

225-88-1329

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7-18-57

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

43 ROSEWOOD LANE

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 TH GRADECollege (1-4 or 5+)
2 YRS (AA)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business/Industry

DRY CLEANING

17. Father's Name (First, Middle, Last)

FELIX GRAVES

18. Mother's Name (First, Middle, Maiden Surname)

BETSY

19e. Informant's Name/Relationship (Type, Print)

REGINALD LEWIS / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

43 ROSEWOOD LANE, OWINGS MILLS, MD. 21117

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT HILL CEMETERY

Date

7-19-97 LYNCHBURG, VA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Head Injuries

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

7-13-97

28b. Time of Injury

2:20 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Automobile accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Beltway 495
Montgomery County, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22164

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen

2. Date of Death

Lake

Month Day Year
July 16th 1997

3. Time of Death

7:00 PM

4a. Facility Name (If not institution, give street and number)

JOSEPH RICHY HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213 14 9779

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2/28/24

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2632 W. LAFAYETTE AVE.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRO
AMERICAN

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERICAL WORKER

16b. Kind of Business/Industry

BALTIMORE CITY
DEPT. OF AGING

17. Father's Name (First, Middle, Last)

AARON WHITE

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE WHITE

19a. Informant's Name/Relationship (Type, Print)

ANNIE WHITE SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

600 LIGHT ST. BALTO. MD. 21230 (APT. 334)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CROWNSVILLE V.A.

Date

7/23/97

20c. Location - City or Town, State

CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee

Leah A. Dwyer

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTO. MD. 21217Physician
/Medical
Examiner

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory arrest

Due to (or as a consequence of):

Carcinoma of unknown etiology

Due to (or as a consequence of):

Metastatic disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

5 min

1 year

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes 20 yrs

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John W. Paine, MD

29c. License number

D13012

29d. Date signed (Month, Day, Year)

16 July 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6545 N. Charles Street Baltimore, Md 21204

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#26 PER PHYNS FLM#G749 7/22/97 J.A.

Certificate of Death

Reg. No.

97 22165

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD LOMAX

2. Date of Death

Month Day Year
07 01 97

3. Time of Death

8:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

Prince George's

5. Social Security Number

212-90-1262

6. Sex

15 M 20 F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

01-01-64

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

145 N. MONTFORD AVE

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LABOR

16b. Kind of Business/Industry

Odd Jobs

17. Father's Name (First, Middle, Last)

JAMES LOMAX

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY BROWN

19a. Informant's Name/Relationship (Type, Print)

ANGELA LOMAX-WIFE

19b. Mailing Address (Street and Number, City or Town, State, Zip Code)

145 N. MONTFORD AVE. 21224

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

VOSCHELL CEMETERY 7/8/97 BALTO. MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

1639 N. BROADWAY BALTO. MD 21213
JEFF MILLER P.C. FUNERAL HOME & SERVICE23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. CRYPTOCOCCAL SEPSIS.

Due to (or as a consequence of):

b. PNEUMOCYSTIS CARINII

Due to (or as a consequence of):

c. ACQUIRED Immunodeficiency Syndrome

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
2 Accident 6 investigation
3 Suicide 6 Could not be
4 Homicide 6 determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 Yes 2 No

28e. Place of Injury - At home, term, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Jeff Miller

29c. License number

D42804

29d. Date signed (Month, Day, Year)

7/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Asresahegn Getachew, Laurel Regional Hosp.

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22166

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ELVIRA MENDEZ

2. Date of Death
Month Day Year

JULY

12, 1997

3. Time of Death

9:40 pm

4a. Facility Name (If not institution, give street and number)

RIVERVIEW NURSING CENTRE

4b. City, Town, or Location of Death

ESSEX

4c. County of Death

BALTIMORE

5. Social Security Number

214-74-9617

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

Nov. 13, 1906

9. Birthplace (State or Foreign
Country)

Mexico

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 Eastern Avenue

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unk.

18. Mother's Name (First, Middle, Maiden Surname)

Unk.

19a. Informant's Name/Relationship (Type, Print)

Frances Beachy/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9127 Todd Ave., Fort Howard, Md. 21052

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gardens of Faith Cemt. 7-17-97 Rossville, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton Funeral Home, Inc.

2134 Willow Spring Rd., Balto., Md. 21222

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Atherosclerotic Cardiovascular Disease 22 years

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. Deshpande

29c. License number

D46082

29d. Date signed (Month, Day, Year)

7/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEETA DESHPANDE, M.D.
1 EASTERN BLVD., BALTIMORE, MD 21221

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22167

Item 7 Per FH Film G749 7-22-97 rja

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert P. Mullin

2. Date of Death
Month Day Year

7

16

97

3. Time of Death

4:42 p

4e. Facility Name (If not institution, give street and number)

University Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

578-78-8305

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

40

Yrs.

If Under 1 Year

Months Days

2

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

7-14-57

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

910 W. Lemmon Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembler

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

John Edward Mullin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Madeline Promutico

19a. Informant's Name/Relationship (Type, Print)

Betty Johnson/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3000 Ohio Avenue, Baltimore, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

7-21-97

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home
at Meadowridge Memorial Park, Inc. 7250
Washington Blvd., Elkrige, Md. 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebral herniation

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 hours

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Central nervous system lymphoma

Due to (or as a consequence of):

2 months

c. Human immunodeficiency virus (HIV) infection

Due to (or as a consequence of):

dx 6/6/97

2 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of intravenous drug abuse

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D23809

29d. Date signed (Month, Day, Year)

7/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Austin Doyle, M.D., Greenbaum Cancer Ctr., 22 S. Greene St., Balt. 21201

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22168

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albert MARTINAK				2. Date of Death Month July Day 18 Year 1997		3. Time of Death 9:12pm	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216123199		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) OCT 2, 1921	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location ROSEDALE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 204 PATAPSCO AVENUE		10f. Zip Code 21237		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE		16b. Kind of Business/Industry MACHINE SHOP			
	17. Father's Name (First, Middle, Last) JOSEPH L. MARTINAK				18. Mother's Name (First, Middle, Maiden Surname) MARY V. BENDER			
	19a. Informant's Name/Relationship (Type, Print) CHARLOTTE W. MARTINAK / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 PATAPSCO AVE ROSEDALE, MARYLAND 21237			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VA CEM		20c. Location - City or Town, State 7/23/97 BALTO, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 1211 CHESACO AVE 21237 CVACH/ROSEDALE FUNERAL HOME			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Acute Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Acute Respiratory Failure Due to (or as a consequence of): Pneumonia							
	Approximate Interval Between Onset and Death 3 days							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day, Year) 7/23/97								
28b. Time of Injury M								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 								
29c. License number D48185								
29d. Date signed (Month, Day, Year) July 18, 1997								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gardar Gislason MD 9000 Franklin Square Drive Baltimore, Maryland 21237								
31. Date filed (Month, Day, Year) JUL 22 1997								
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97-3983-510
B.K.S
ARTHUR MANNING

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

97 22169

Items: 16b, 20a per F.H. G-749 7/22/97 reb **Certificate of Death**

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur Manning

2. Date of Death

Month Day Year
JULY 17, 1997

3. Time of Death

12:27 PM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL E.R.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

066-01-3690

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 17, 1917

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

FL

10b. County

Palm Beach

10c. City, Town or Location

Boca Raton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

320 Plaza Real #503

10f. Zip Code

33432

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

RETAIL
Book Store

17. Father's Name (First, Middle, Last)

Hymie Manowitz

18. Mother's Name (First, Middle, Maiden Surname)

Ann Tash

19a. Informant's Name/Relationship (Type, Print)

Thomas Manning/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

320 Plaza Real #503, Boca Raton, FL 33432

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Palm Beach Mem. Park

Date

7/20/97

20c. Location - City or Town, State

Lantana, FL

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling Ashton Funeral Home, Inc
736 Edmondson Avenue, Balto, Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

INSPECTION

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute M.D.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JUL 22 1997

Registrar's Signature

Baltimore, Maryland 21215-0020

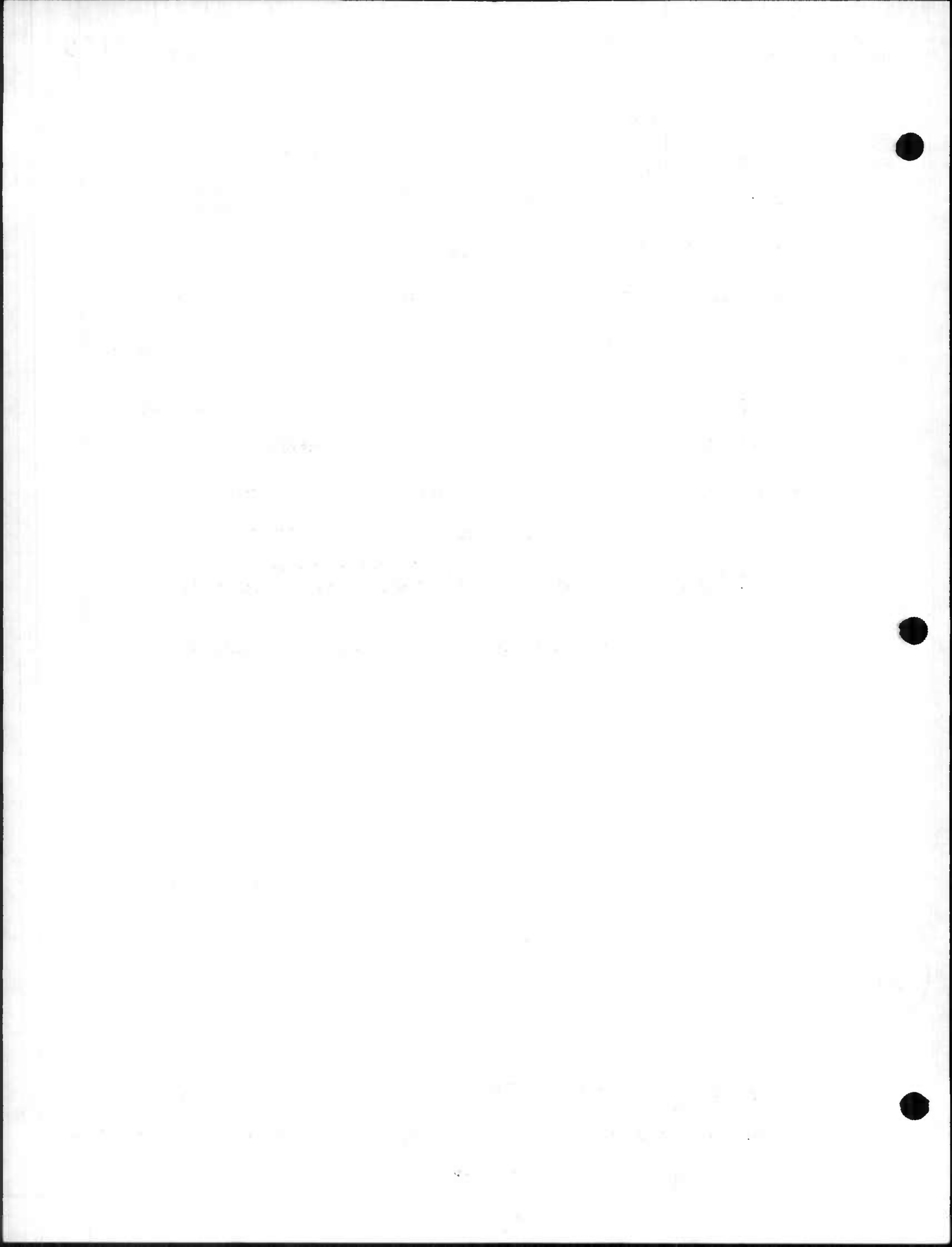
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22170

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie M. Marecki				2. Date of Death Month 7 Day 18 Year 97		3. Time of Death 5:40 AM		
	4a. Facility Name (If not Institution, give street and number) Mercy Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA		
Funeral Director	5. Social Security Number 213-01-4697		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 20 16 Maryland	9. Birthplace (State or Foreign Country)	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Hartford		10c. City, Town or Location Abingdon		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 108 Boxthorn Road				10f. Zip Code 21009		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Joseph Chojnacki				18. Mother's Name (First, Middle, Maiden Surname) Pelagia Wasonicz				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Susan Morrison (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Boxthorn Rd. Abingdon, Md. 21009				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith July 21		20c. Location - City or Town, State Baltimore, Md.				
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility W. Dabrowski/Chojnacki F.H.P.A. 1005 Dundalk Ave. Baltimore, Md. 21224				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Renal Failure							Approximate Interval Between Onset and Death 2 wks	
	Due to (or as a consequence of): Arteriosclerotic Cardiovascular disease yrs								
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure Dissecting aneurysm of aorta							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Louis E. Grenzer</i>							
		29c. License number D01442		29d. Date signed (Month, Day, Year) 7/18/97					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Louis E. Grenzer 301st. Paul Pl. Suite 815 B. It Md 21202									
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22171

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Snyder McGee

2. Date of Death

Month JULY 19 Day 19 Year 1997

3. Time of Death

11:20 am

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

215-09-1365

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 31, 1915

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

800 Southerly Rd. Unit 1506

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles A. Snyder

18. Mother's Name (First, Middle, Maiden Surname)

Florence Deffinbaugh

19a. Informant's Name/Relationship (Type, Print)

Richard P. McGee (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1313 Milldam Rd. Towson, MD. 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Mem. Gard. 7/23/97

Date

20c. Location - City or Town, State

Timonium, MD.

21. Signature of Funeral Service Licensee

D. C. Carroll

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Sepsis syndrome

Due to (or as a consequence of):

b. ischemic bowel

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. C. Carroll MD

29c. License number

D50893

29d. Date signed (Month, Day, Year)

7/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MDENUS / 666566 N CHARLES, BALTO MD 21286

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State
RegistrarMcGee, Dorothy S.
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

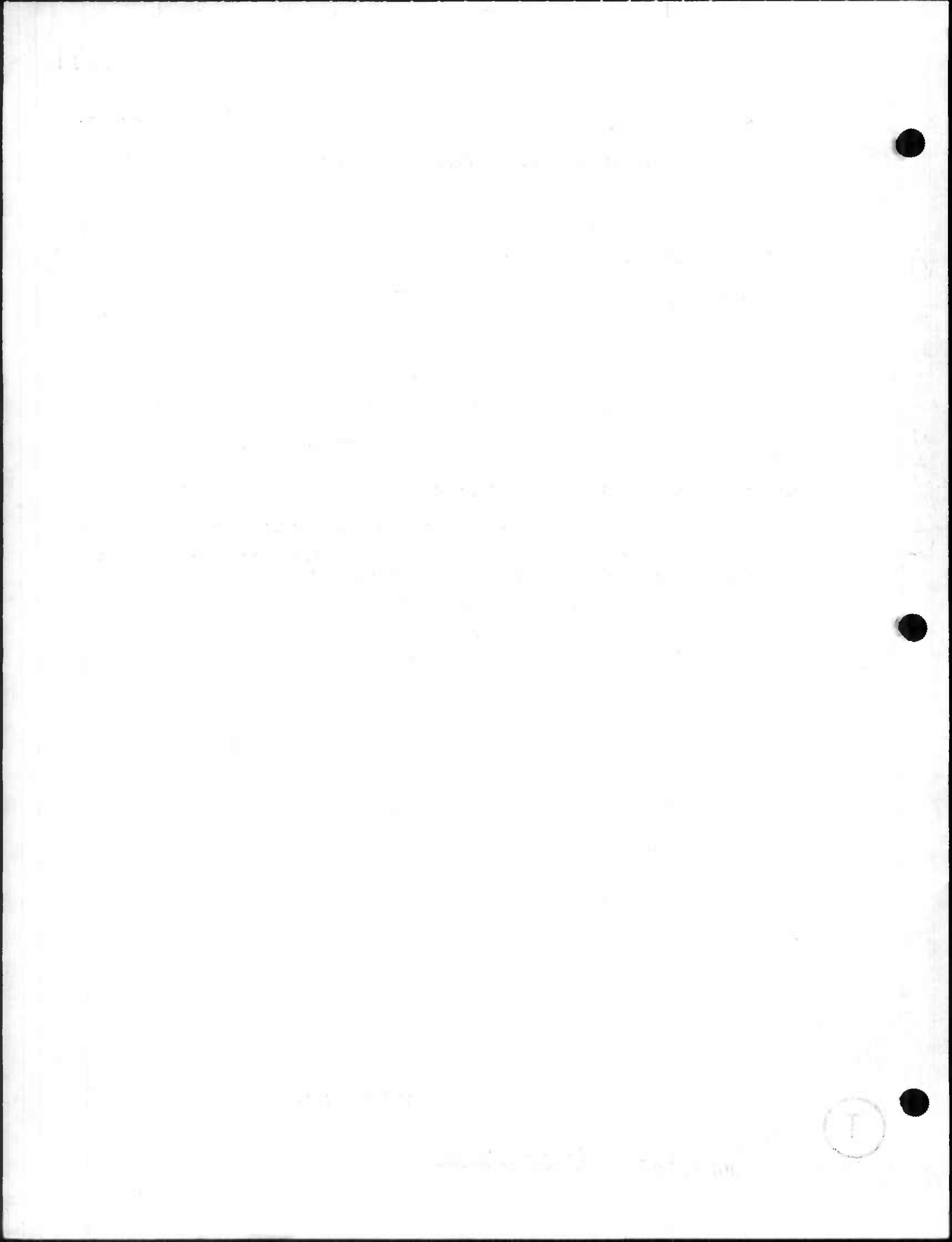
Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

T

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) ADELINE F MOOG		2. Date of Death Month 07 Day 19 Year 97		3. Time of Death 12:30PM	
4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 214-50-3637	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 19 1914	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent					
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Dundalk		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1941 Dineen Drive		10f. Zip Code 21222		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) James A. Jenkins		18. Mother's Name (First, Middle, Maiden Surname) Annie M Not Known			
19a. Informant's Name/Relationship (Type, Print) Robert Moog/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9644 Manifold Road New Park, PA 17352			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Location - City or Town, State 7/21/97 Towson, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. chronic obstructive pulmonary disease			Approximate Interval Between Onset and Death 20yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Victoria Porter MD		29c. License number 97023		29d. Date signed (Month, Day, Year) July 19, 1997	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) VICTORIA PORTER MD JOHNS HOPKINS BAYVIEW MEDICAL CENTER					
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature 			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22173**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Henry Maul, Jr.				2. Date of Death Month July Day 11 Year 1997		3. Time of Death 2:30 AM	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-01-4903		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 15, 1917	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 1801 Walnut Avenue				10f. Zip Code 21222		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction		16b. Kind of Business/Industry Home & Sales		
17. Father's Name (First, Middle, Last) John H. Maul, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Omeis				
19a. Informant's Name/Relationship (Type, Print) Ronald L. Maul/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Walnut Avenue Baltimore, Maryland 21222				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Data 7/14/1997		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. MASSIVE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. DUODENAL ULCER Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 10 MINUTES 3 DAYS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. UTI, TYPE 2 DM, OSTEOMYELITIS						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D46360		29d. Date signed (Month, Day, Year) 7/21/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL A. ANKROM MD				5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD 21224				
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22174

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Johanna Mehm

2. Date of Death

Month Day Year
July 16, 1997

3. Time of Death

12:40P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Genesis Nursing Home Severna Park

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

5. Social Security Number

216-01-8209

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 21, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

106 East West Street

10f. Zip Code

21230

10g. Citizen of What Country?

U., S., A

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Hochild Kohn

17. Father's Name (First, Middle, Last)

John L.C. Mehm

18. Mother's Name (First, Middle, Maiden Surname)

Rosa May Vogel

19a. Informant's Name/Relationship (Type, Print)

John Simmons (Friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

400 Seventh Avenue North East Glen Burnie, MD. 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

7/18/97

20c. Location - City or Town, State

Brooklyn Park, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Homes
130 East Fort Ave. Balto., MD. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE

5 YEARS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SUZANA MUNDRA MD 203 E PATAPSCO AV BALTIMORE 21221

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

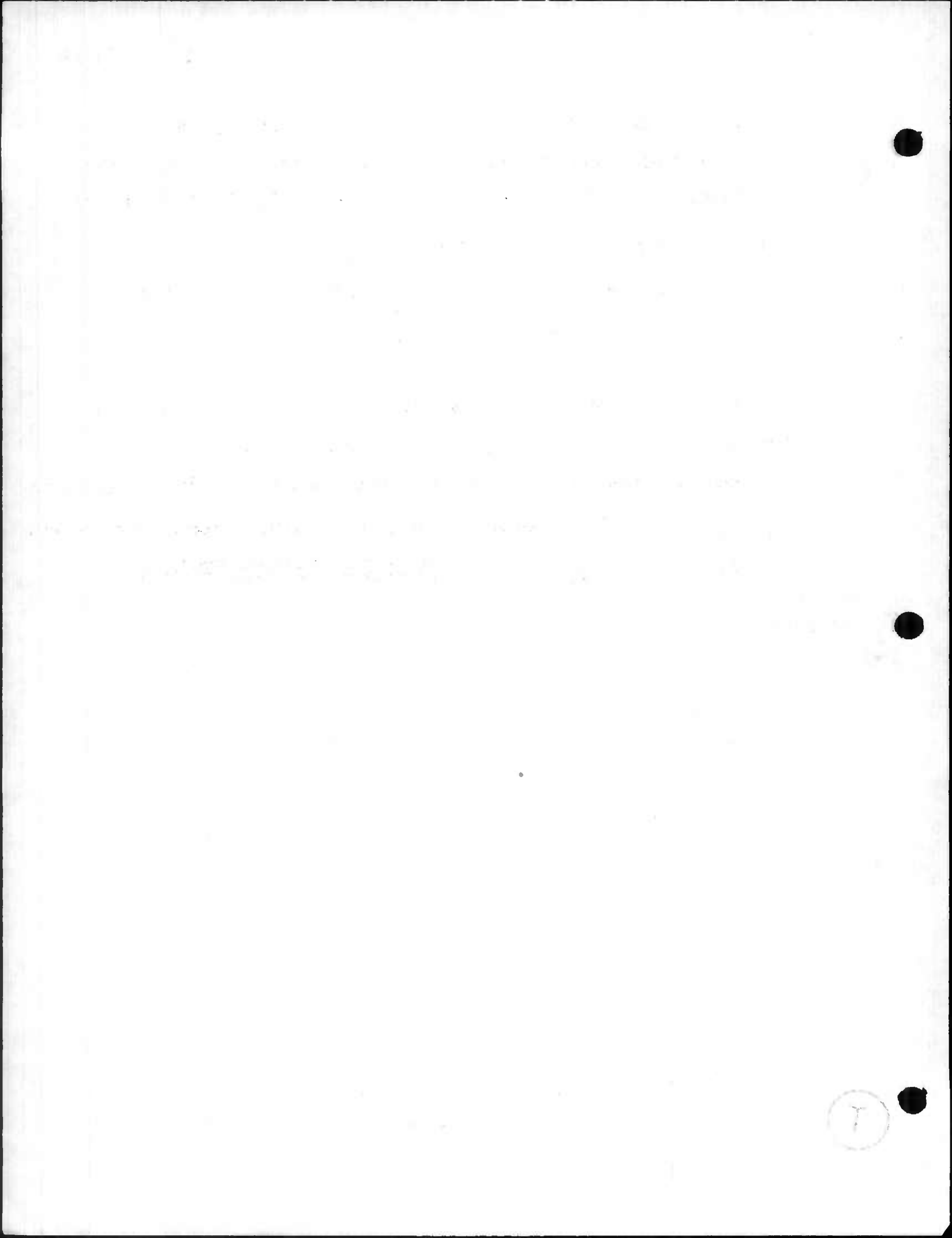
Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

T



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22175

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Eleanor, M. Marston</i>					2. Date of Death Month <i>July</i> Day <i>19th</i> Year <i>1997</i>			3. Time of Death <i>2:50 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Keswick Nursing Home</i>					4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>220-44-2964</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <i>79</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Nov. 15, 1917</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>700 W. 40th Street</i>				10f. Zip Code <i>21211</i>		10g. Citizen of What Country? <i>United States</i>			
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Home</i>			
	17. Father's Name (First, Middle, Last) <i>Robert Webster Macdonald</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Josephine Myers</i>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Anne Marston Pries - daughter</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>566 W. University Parkway, Baltimore, MD 21210</i>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Fort Lincoln Crematory</i>		Data <i>7/21/97</i>		20c. Location - City or Town, State <i>Brentwood, MD</i>		
	21. Signature of Funeral Service Licensee <i>Ann Zink</i>				22. Name and Address of Facility <i>Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, MD 21229</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. <i>Cerebrovascular Accident (L) Hemiplegia</i></p> <p style="text-align: center;">Dua to (or as a consequence of):</p> <p>b. <i>2. FUSE ARTERIOLECTIC Cerebrovascular Disease</i></p> <p style="text-align: center;">Dua to (or as a consequence of):</p> <p>c. _____</p> <p style="text-align: center;">Dua to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><i>6 Yrs</i></p> <p><i>26 Yrs</i></p> </div> </div>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cancer of Breast</i> <i>Possible Hemochromatosis</i>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>John Davidson-Randall</i>			29c. License number <i>12355</i>		29d. Date signed (Month, Day, Year) <i>July 19, 1997</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Charles S. Jordan Jr., M.D. - Keswick 700 W. 40th St. Baltimore, MD 21211</i>										
31. Date filed (Month, Day, Year) <i>JUL 22 1997</i>			32. Registrar's Signature <i>John Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1952-1953

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and the results of the various projects.

2. The second part of the report deals with the financial situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and the results of the various projects.

3. The third part of the report deals with the social situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and the results of the various projects.

4. The fourth part of the report deals with the economic situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and the results of the various projects.

5. The fifth part of the report deals with the cultural situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and the results of the various projects.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22176

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cornelia Irene Naus				2. Date of Death Month Day Year July 20 1997		3. Time of Death 3:00 pm	
	4a. Facility Name (If not institution, give street and number) Ivy Hall Geriatric				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-16-7687A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 11-11-1911	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3729 E. Lombard Street		10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry In own home			
	17. Father's Name (First, Middle, Last) Frank Brightwell				18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Cox			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Daughter Mary Dorbert				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1540 Rosewick Avenue, Baltimore, Md. 21237			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		20c. Date 7/23/97		20d. Location - City or Town, State Baltimore, MD.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Joseph N. Zannino</i>				22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm. 263 S. Conkling St. Baltimore, Maryland 21224			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CARCINOMA OF LUNG WITH METASTASIS unknown Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Saunders & Truitt M.D.</i>				29c. License number D27188		29d. Date signed (Month, Day, Year) 7/21/97	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Saunders & Truitt 2 Market Place Dundalk 21222 MD							
State Registrar	31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature <i>Julia Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

JA

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TIMOTHY NICKENS JR				2. Date of Death Month Day Year JULY 16, 1997		3. Time of Death 11:25AM	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL C.C.U				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-96-9154		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 16 Yrs.		8. Date of Birth (Month, Day, Year) FEB 14, 1981	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 910 E. LOMBARD ST		10f. Zip Code 21202		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT		16b. Kind of Business/Industry BALTO. CITY PUBLIC SCHOOL		17. Father's Name (First, Middle, Last) TIMOTHY NICKENS, SR.	
	18. Mother's Name (First, Middle, Maiden Surname) GLADYS HARPER		19a. Informant's Name/Relationship (Type, Print) GLADYS HARPER (MOTHER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 E. LOMBARD ST. BALTO., MD 21202		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) VOSHALL MEM		20c. Location - City or Town, State BALTO., MD		21. Signature of Funeral Service Licensee Calvin L. Williams		22. Name and Address of Facility CALVIN L. WILLIAMS F.S. 270 Fredrickson Pass Balto., MD	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Drowning Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 7/16/97	
	28b. Time of Injury 0020 A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject drowned		28e. Location (Street and Number or Rural Route Number, City or Town, State) Inner Harbor near 2016 Pratt St Baltimore, Md	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dennis J. Chute, MD		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 17, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature Julia Davidson-Randall			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22178**

Item: 5 per Personal Rep. 2/23/99 G-768 re **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHANNA OLIVER				2. Date of Death Month JULY Day 11 Year 1997		3. Time of Death 08:30 AM FOUND	
	4a. Facility Name (If not institution, give street and number) 8104 15th AVENUE #4				4b. City, Town, or Location of Death LANGLEY PARK		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 385-20-2753		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 14, 1925	
	9. Birthplace (State or Foreign Country) Michigan		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Hyattsville	
Usual Residence of Decedent								
10a. State Maryland			10b. County Prince Georges			10c. City, Town or Location Hyattsville		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number 8104 15th Avenue			10f. Zip Code 20783		
10g. Citizen of What Country? U.S.A.			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: B White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor			16b. Kind of Business/Industry Telephone			17. Father's Name (First, Middle, Last) unknown		
18. Mother's Name (First, Middle, Maiden Surname) unknown			19a. Informant's Name/Relationship (Type, Print) Ronald S. Wade, Director			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state			20b. Place of Disposition (Name of cemetery, crematory or other place) Data			20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director			22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d.		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		
28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Mario F. Golle, Jr. MD			29c. License number 033954			29d. Date signed (Month, Day, Year) JULY 13, 1997		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) MARIO F. GOLLE, JR. MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785								
31. Date filed (Month, Day, Year) JUL 22 1997			32. Registrar's Signature Randall					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

05154-10

10-5

10-10

10-15

10-20

10-25

10-30

10-35

10-40

10-45

10-50

10-55

11-00

11-05

11-10

11-15

11-20

11-25

11-30

11-35

11-40

11-45

11-50

11-55

12-00

12-05

12-10

12-15

12-20

12-25

12-30

12-35

12-40

12-45

12-50

12-55

1-00

1-05

1-10

1-15

1-20

1-25

1-30

1-35

1-40

1-45

1-50

1-55

2-00

2-05

2-10

2-15

2-20

2-25

2-30

2-35

2-40

2-45

2-50

2-55

3-00

3-05

3-10

3-15

3-20

3-25

3-30

3-35

3-40

3-45

3-50

3-55

4-00

4-05

4-10

4-15

4-20

4-25

4-30

4-35

4-40

4-45

4-50

4-55

5-00

5-05

5-10

5-15

5-20

5-25

5-30

5-35

5-40

5-45

5-50

5-55

6-00

6-05

6-10

6-15

6-20

6-25

6-30

6-35

6-40

6-45

6-50

6-55

7-00

7-05

7-10

7-15

7-20

7-25

7-30

7-35

7-40

7-45

7-50

7-55

8-00

8-05

8-10

8-15

8-20

8-25

8-30

8-35

8-40

8-45

8-50

8-55

9-00

9-05

9-10

9-15

9-20

9-25

9-30

9-35

9-40

9-45

9-50

9-55

10-00

10-05

10-10

10-15

10-20

10-25

10-30

10-35

10-40

10-45

10-50

10-55

11-00

11-05

11-10

11-15

11-20

11-25

11-30

11-35

11-40

11-45

11-50

11-55

12-00

12-05

12-10

12-15

12-20

12-25

12-30

12-35

12-40

12-45

12-50

12-55

1-00

1-05

1-10

1-15

1-20

1-25

1-30

1-35

1-40

1-45

1-50

1-55

2-00

2-05

2-10

2-15

2-20

2-25

2-30

2-35

2-40

2-45

2-50

2-55

3-00

3-05

3-10

3-15

3-20

3-25

3-30

3-35

3-40

3-45

3-50

3-55

4-00

4-05

4-10

4-15

4-20

4-25

4-30

4-35

4-40

4-45

4-50

4-55

5-00

5-05

5-10

5-15

5-20

5-25

5-30

5-35

5-40

5-45

5-50

5-55

6-00

6-05

6-10

6-15

6-20

6-25

6-30

6-35

6-40

6-45

6-50

6-55

7-00

7-05

7-10

7-15

7-20

7-25

7-30

7-35

7-40

7-45

7-50

7-55

8-00

8-05

8-10

8-15

8-20

8-25

8-30

8-35

8-40

8-45

8-50

8-55

9-00

9-05

9-10

9-15

9-20

9-25

9-30

9-35

9-40

9-45

9-50

9-55

10-00

10-05

10-10

10-15

10-20

10-25

10-30

10-35

10-40

10-45

10-50

10-55

11-00

11-05

11-10

11-15

11-20

11-25

11-30

11-35

11-40

11-45

11-50

11-55

12-00

12-05

12-10

12-15

12-20

12-25

12-30

12-35

12-40

12-45

12-50

12-55

1-00

1-05

1-10

1-15

1-20

1-25

1-30

1-35

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Michael Oleniacz				2. Date of Death Month July Day 20 Year 1997		3. Time of Death 6:15 AM	
4a. Facility Name (If not institution, give street and number) Franklin Woods Nursing Home				4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore	
5. Social Security Number 213-18-6808		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 12, 1921	
9. Birthplace (State or Foreign Country) Pennsylvania							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 7637 South Bend Road				10f. Zip Code 21222		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Years College (1-4or 5+) Longshoreman				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipping		16b. Kind of Business/Industry Shipping	
17. Father's Name (First, Middle, Last) Joseph Oleniacz				18. Mother's Name (First, Middle, Maiden Surname) Mary Helon			
19a. Informant's Name/Relationship (Type, Print) Kathlyn M. Oleniacz/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7637 South Bend Road Baltimore, Maryland 21222			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Grdns.		20c. Location - City or Town, State 7/25/1997 Bel Air, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer of the lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5 months Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							Approximate Interval Between Onset and Death 5 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier MD				29c. License number D18487		29d. Date signed (Month, Day, Year) 7/21/97	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO THANT 6830 HOSPITAL DRIVE, BALTO, MD 21237							
31. Date filed (Month, Day, Year) JUL 22 1997				Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22180

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) June I. O'Brien				2. Date of Death Month Day Year July 20 1997				3. Time of Death 12:25 PM	
	4a. Facility Name (If not institution, give street and number) Mercy Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 512-14-9033		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) June 11 1918		9. Birthplace (State or Foreign Country) Kansas		10a. State Md		10b. County Baltimore		10c. City, Town or Location Baltimore Co Md.	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 423 Pembroke Blvd.		10f. Zip Code 21224		10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Saleslady	
	16b. Kind of Business/Industry Dept. Store		17. Father's Name (First, Middle, Last) Russell Widup		18. Mother's Name (First, Middle, Maiden Surname) Clara Starr		19a. Informant's Name/Relationship (Type, Print) Paul W. O'Brien		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 Pembroke Blvd. Baltimore, Md. 21224	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory		20c. Location - City or Town, State 7/23/97 Baltimore		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hartley Miller Funeral Home 7527 Harford Rd., Baltimore, Md. 21234	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE CEREBRAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Approximate Interval Between Onset and Death 1 DAY	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and Title of certifier 		29c. License number D21338		29d. Date signed (Month, Day, Year) JULY 20, 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN SWEETMAN MD. 3509 Churchville RD ABERDEEN MD. 21001		31. Date filed (Month, Day, Year) JUL 22 1997	
	32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

A

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion and summary of the work.

5. The fifth part is a list of references.

6. The sixth part is a list of figures.

7. The seventh part is a list of tables.

8. The eighth part is a list of appendices.

9. The ninth part is a list of footnotes.

10. The tenth part is a list of symbols.

11. The eleventh part is a list of abbreviations.

12. The twelfth part is a list of acknowledgments.

13. The thirteenth part is a list of references.

14. The fourteenth part is a list of figures.

15. The fifteenth part is a list of tables.

16. The sixteenth part is a list of appendices.

17. The seventeenth part is a list of footnotes.

18. The eighteenth part is a list of symbols.

19. The nineteenth part is a list of abbreviations.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22181

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDITH M. PRUSS

2. Date of Death

Month Day Year
07 -19 -1997

3. Time of Death

4:00pm

4a. Facility Name (If not institution, give street and number)

ROLAND PARK PLACE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-20-3148

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
09-08-1901

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

830 WEST 40TH ST.

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DEPT. OF EDUCATION

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

JOHN F. PRUSS

18. Mother's Name (First, Middle, Maiden Surname)

ANNA LANGLOTZ

19a. Informant's Name/Relationship (Type, Print)

ADELE PRUSS (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5221 EllicoTT Drive Centreville, Va. 20120

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GREEN MOUNT CREMATORY 07/22/97 BALTO., MD.

Date

20c. Location (City or Town, State)

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

5 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GLAUCOMA, MACULAR DEGENERATION

OSTEOPOROSIS

BREAST CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

037133

29d. Date signed (Month, Day, Year)

7/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONNA DOW M.D. 7600 OSLER DRIVE TOWSON, MD. 21204.

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

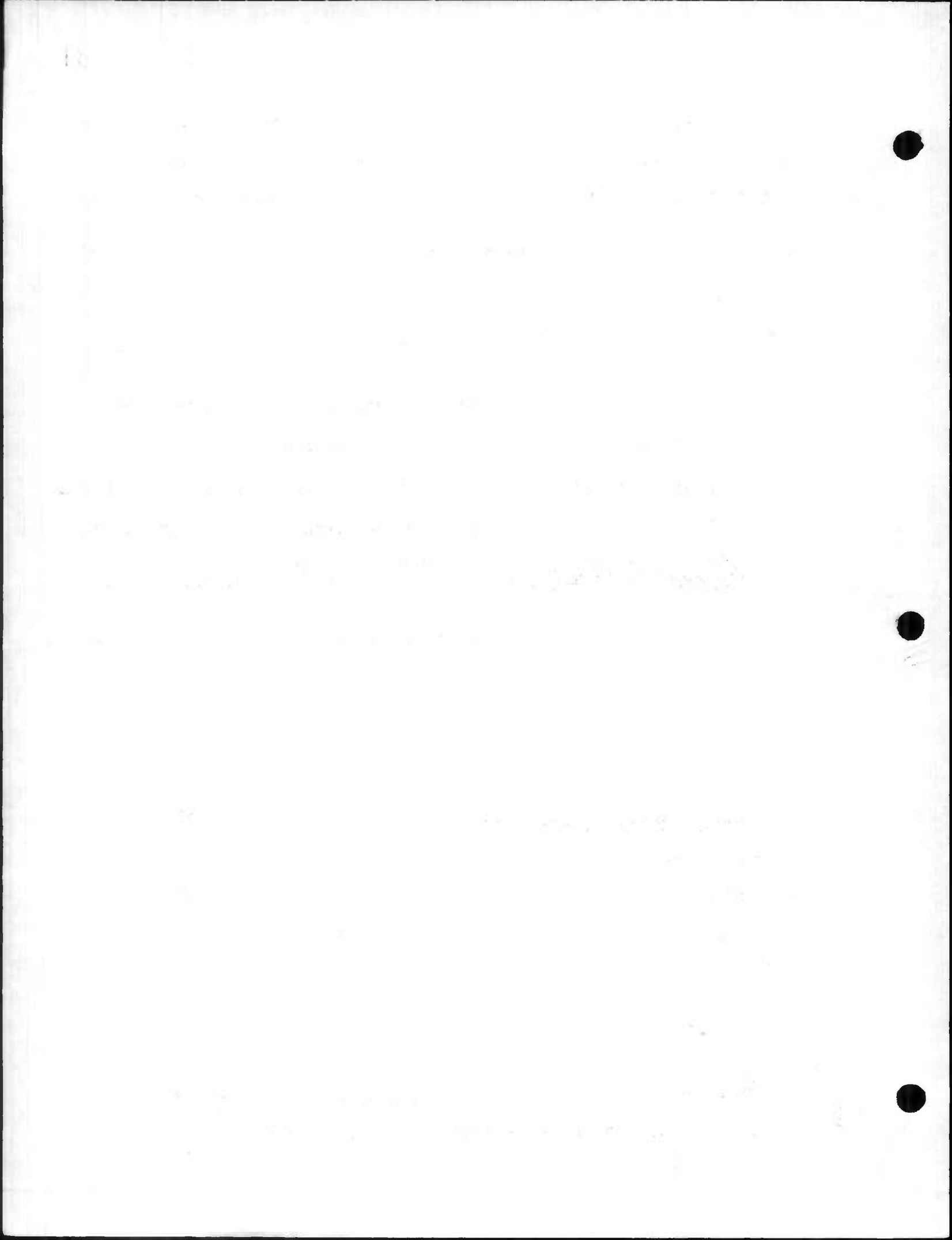
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22182

Items: 1 per MD, 18 per FH G-750 8/15/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN LEICH PARKHURST

2. Date of Death

07 19 97

3. Time of Death

1130

4e. Facility Name (If not institution, give street and number)

9307 Hallsboro Circle, Apt. 301

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-46-7302

6. Sex

M ☐ F ☐

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 27, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9307 Hallsboro Circle, Apt. 301

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Volunteer

16b. Kind of Business/Industry

Various Organizations

17. Father's Name (First, Middle, Last)

George Veasey Parkhurst

18. Mother's Name (First, Middle, Maiden Surname)

Martha Leich LEICH

19a. Informant's Name/Relationship (Type, Print)

Martha L. Parkhurst/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4513 Roland Ave., Baltimore, MD 21210

20a. Method of Disposition

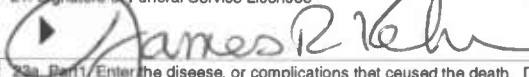
☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Green Mount Crematory 7/22/97 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Henry W. Jenkins & Sons
4905 York Rd., Baltimore, MD 2121223a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute myocardial infarction

Due to (or as a consequence of):

b. Chronic hypertensive cardiovascular disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

7 years

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic schizophrenia

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Crossan O'Donovan, M.D.

29c. License number

D07632

29d. Date signed (Month, Day, Year)

07-21-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. Crossan O'Donovan M.D., 2112 DUNDALK AVE., BALTO. MD 21222

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

AM
ROBERT
PARKER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97-22183

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



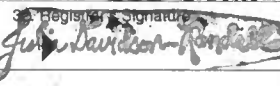
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Robert Allen Parker		2. Date of Death Month Day Year JULY 15, 1997		3. Time of Death 1220 P
4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL S.T.U.		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
5. Social Security Number 212-08-6771	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 25 Yrs.	If Under 1 Year Months Days 1 32	8. Date of Birth (Month, Day, Year) Oct. 12, 1971
Usual Residence of Decedent		9. Birthplace (State or Foreign Country) New York		
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 304 Highland Drive		10f. Zip Code 21061		10g. Citizen of What Country? U.S.A.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator		16b. Kind of Business/Industry Tate Access Flooring
17. Father's Name (First, Middle, Last) Darryl Parker		18. Mother's Name (First, Middle, Maiden Surname) Susan Williams		
19a. Informant's Name/Relationship (Type, Print) Darryl Parker Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2958 Almondbury Drive Pasadena, Maryland 21122		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery July 18, 1997		20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Contact gunshot wound of head Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? partial <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 7-15-97		28b. Time of Injury 11 32 M
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot self		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 304 Highland Dr. #203		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of Certifier 		
29c. License number OCME		29d. Date signed (Month, Day, Year) JULY 16, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201				
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature 		

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22184

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RONALD EMERSON PRYBA				2. Date of Death Month Day Year JULY 19, 1997		3. Time of Death 12:15 PM	
	4a. Facility Name (If not institution, give street and number) 707 HUNTING PLACE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 398-30-8011		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) 1/26/1936	
	9. Birthplace (State or Foreign Country) WISCONSIN							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 707 HUNTING PLACE				10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ Collage (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER		16b. Kind of Business/Industry DEFENSE COMPANY			
	17. Father's Name (First, Middle, Last) EDWARD S. PRYBA				18. Mother's Name (First, Middle, Maiden Surname) TESSIE (FLEISCHMAN)			
	19a. Informant's Name/Relationship (Type, Print) JACOB PRYBA (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 HUNTING PLACE BALTIMORE, MD 21229			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CATHOLIC CEMETERY		Date 7/23/97		20c. Location - City or Town, State GEORGIA	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Myocardial Infarction 6/14/97 Hypertension							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number BK 4995726		29d. Date signed (Month, Day, Year) 7/21/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bryan S. Khim 2850 N. Ridge Road, Suite 103 Ellicott City MD 21042								
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22185

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gary Edwin PORTER

2. Date of Death

Month Day Year
July 20, 1997

3. Time of Death

3:17pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

219-40-0460

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
November 11, 1943

9. Birthplace (State or Foreign Country)

Baltimore Co., Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1208 Kelly Case Lane

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Operation Analyst

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Harry F. Porter

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn T. Hellman

19a. Informant's Name/Relationship (Type, Print)

Kelly Porter Butler (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1208 Kelly Case Lane Baltimore, Maryland 21221

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery July 24, 1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Deborah Hopkins

22. Name and Address of Facility

Lassahn Funeral Home, Inc.

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Syncope

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

75 minutes

b. Ventricular Fibrillation Arrest

Due to (or as a consequence of):

75 minutes

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Deborah Hopkins MD

29c. License number

D51692

29d. Date signed (Month, Day, Year)

July 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Deborah Hopkins MD 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

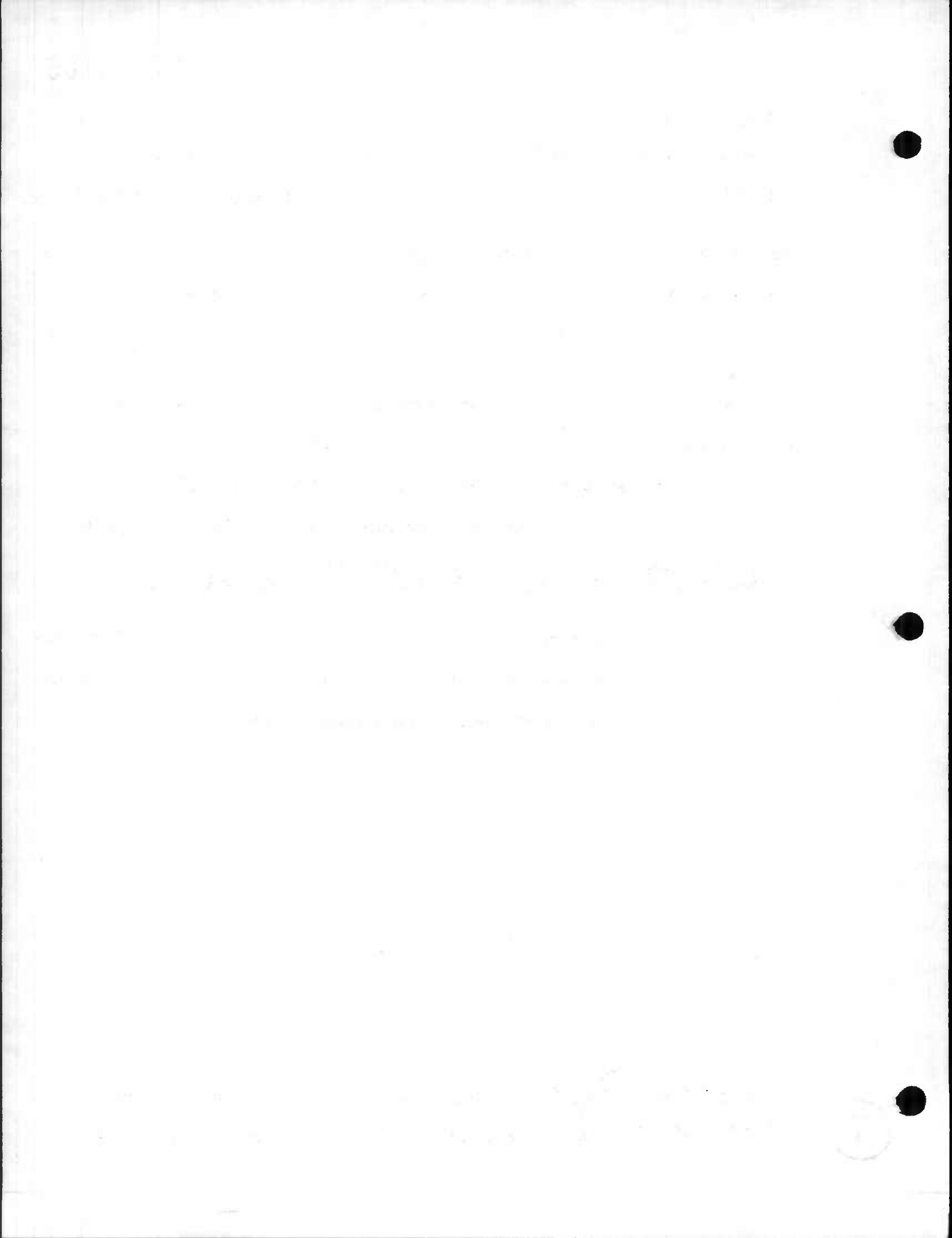
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

T



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22186

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN F. RICHARDSON, SR.

2. Date of Death

Month

Day

Year

JULY 16 1997

3. Time of Death

5:40A

4a. Facility Name (If not institution, give street and number)

GENESIS ELDER CARE

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

223-26-8145

6. Sex

M 20 F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

DEC 29, 1909

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

Maryland

10b. County

BALTIMORE

10c. City, Town or Location

Randallstown

10d. Inside City Limits

Yes 20 No

10e. Street and Number

4103 Holbrook Road

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes 20 No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
10 Yes 20 No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th grade

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Packer

16b. Kind of Business/Industry

L.A. Benson
Company

17. Father's Name (First, Middle, Last)

ELIJAH RICHARDSON

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE PINK OSBORN

19a. Informant's Name/Relationship (Type, Print)

LOONIE RICHARDSON / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4103 Holbrook Road Randallstown, Maryland 21133

20a. Method of Disposition

20 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Crest Lawn Mem. Garden

Date

7/16/97

20c. Location - City or Town, State

Ellicott City, Md

21. Signature of Funeral Service Licensee

Denny Harris

22. Name and Address of Facility

CHATMAN - HARRIS FUNERAL HOME
5540 REISTERSTOWN ROAD
BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Carcinoma of Prostate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending Investigation
20 Accident 60 Could not be determined
30 Suicide 40 Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Denny Harris

29c. License number

D17753

29d. Date signed (Month, Day, Year)

7/16/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

8020 Pyle Rd, Randallstown, Maryland 21133

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature
Judy Davidson-RandallState
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22187

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MONTIE ROBINSON				2. Date of Death Month JULY Day 17 Year 1997		3. Time of Death 5 AM																	
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE																	
Funeral Director	5. Social Security Number 226-07-1099		6. Sex 2 M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEP 28 1913																	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) VIRGINIA																					
To Be Completed by Funeral Director	10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
	10e. Street and Number 7015 LANCASTER ROAD				10f. Zip Code 21207		10g. Citizen of What Country? USA																	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERICAL		16b. Kind of Business/Industry INDUSTRIAL																			
	17. Father's Name (First, Middle, Last) RICHARD MERRITTE ROBINSON, SR.				18. Mother's Name (First, Middle, Maiden Surname) NELLIE HERRMANN																			
	19a. Informant's Name/Relationship (Type, Print) ETHEL G. ROBINSON, WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7015 LANCASTER RD., BALTIMORE, MD 21207																			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LAKEVIEW MEMORIAL PARK		Date 7-21		20c. Location - City or Town, State SYKESVILLE, MD																	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE., BALTIMORE, MD 21228																					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e. ACUTE MYOCARDIAL INFARCTION</td> <td rowspan="4">Approximate Interval Between Onset and Death HOURS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">f. _____</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">g. _____</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">h. _____</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. ACUTE MYOCARDIAL INFARCTION	Approximate Interval Between Onset and Death HOURS	Due to (or as a consequence of):		f. _____		Due to (or as a consequence of):		g. _____		Due to (or as a consequence of):		h. _____		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. ACUTE MYOCARDIAL INFARCTION	Approximate Interval Between Onset and Death HOURS																						
	Due to (or as a consequence of):																							
	f. _____																							
	Due to (or as a consequence of):																							
g. _____		Due to (or as a consequence of):																						
h. _____		Due to (or as a consequence of):																						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZURE DISORDER CHRONIC LYMPHOCYTIC LEUKEMIA						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																								
29b. Signature and title of certifier  K.S. RAO, M.D.		29c. License number 043462		29d. Date signed (Month, Day, Year) JULY 17, 1997																				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD.																								
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature 																						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22188

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WAYNE L. ROUTSON

2. Date of Death

Month JULY Day 20 Year 1997

3. Time of Death

6:35a

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral
Director

5. Social Security Number

218-46-2379

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12/20/1945

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18114 Sky View Lane

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Harry Milton Routson, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Matilda Franke

19a. Informant's Name/Relationship (Type, Print)

Patricia L. Routson (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18114 Sky View Lane Hagerstown, MD. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Mem. Gard.

Date

7/24/97

20c. Location - City or Town, State

Timonium, MD.

21. Signature of Funeral Service Licensee

Dennis C. Canall

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd.

Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BOWEL PERFORATION

Approximate Interval Between Onset and Death

24 hrs

Due to (or as a consequence of):

CHRONIC MYELOGENOUS LEUKEMIA

5 mos

Due to (or as a consequence of):

NEUTROPENIA

1 mo.

Due to (or as a consequence of):

RENAL INSUFFICIENCY

2 wks.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANAL FISTULA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Orłowski MD PhD

29c. License number

046104

29d. Date signed (Month, Day, Year)

7/20/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT ORŁOWSKI, 600 N. WOLFE ST., BALTIMORE MD 21207

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Dawson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22189

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Delbert Leroy Reiner				2. Date of Death Month Day Year JULY 18 1997		3. Time of Death 7:30 AM	
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 213-10-1725		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) May 21, 1916	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 205 East Joppa Road Apt. 1201		10f. Zip Code 21286	
	10g. Citizen of What Country? United States				11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Real Estate Officer				16b. Kind of Business/Industry First National Bank			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Charles Reiner				18. Mother's Name (First, Middle, Maiden Summa) Lydia Bicht			
	19a. Informant's Name/Relationship (Type, Print) Marion Reiner-Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 East Joppa Road Apt. 1201 Baltimore, Md. 21286			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery			
	20c. Location - City or Town, State Baltimore, Maryland				20d. Date 7/19/1997			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Daniel A. Paylor				22. Name and Address of Facility McCully-Polyniak Funeral Home 130 E. Fort Ave. Baltimore, Maryland 21230			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BILIARY sepsis s/p cholecystectomy Due to (or as a consequence of): CHOLECYSTITIS / empyema Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes mellitus. Coronary Artery Disease.				Approximate Interval Between Onset and Death 3wks 6wks			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus. Coronary Artery Disease.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 7/19/1997			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier Rita Pabla MD				29c. License number D47707			
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) JULY 18 1997				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RITA PABLA MD 6565 N Charles St Ste 203 Baltimore MD 21204			
	31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature Johanna Davidson-Rendell			

Reiner, Delbert Leroy
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

T

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22190

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN E. SCHMIDT

2. Date of Death

Month
JULYDay
16Year
97

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-34-2498

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

11-11-1903

9. Birthplace (State or Foreign Country)

SOUTH DAKOTA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1315 WINDEMERE AVE.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

RUDOLPH A. SCHMIDT

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA MAELER

19a. Informant's Name/Relationship (Type, Print)

MARTHA L. REBBERT (DAUGHTER) 8654 BLACK OAK RD. BALTIMORE MD. 21234.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GRACELAND CEM.

Date

07-23-97

20c. Location - City or Town, State

SOUTH DAKOTA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.

4905 YORK RD. BALTO., MD. 21212.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

b.

Aspiration

Due to (or as a consequence of):

4 WEEKS

c.

Generalized Atherosclerotic Vascular Disease

Due to (or as a consequence of):

10 YRS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D45862

29d. Date signed (Month, Day, Year)

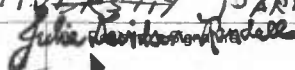
JULY 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 E. UNIVERSITY PARKWAY, BALTIMORE MARYLAND 21218

31. Date filed (Month, Day, Year)

JUL 22 1997

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

T

T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22191**

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Leslie Savage</i>						2. Date of Death Month <i>July</i> Day <i>19</i> Year <i>1997</i>		3. Time of Death <i>9:20 AM</i>													
	4a. Facility Name (If not institution, give street and number) <i>Evergreen Nursing & Rehab. Center</i>						4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Maryland</i>													
Funeral Director	5. Social Security Number <i>239-46-9920</i>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>62</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>February 5, 1935</i>		9. Birthplace (State or Foreign Country) <i>N. Carolina</i>													
	Usual Residence of Decedent																					
10a. State <i>MD</i>		10b. County <i>n/a</i>		10c. City, Town or Location <i>BALTIMORE</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
10e. Street and Number <i>2808 RUSCOMBE LANE</i>					10f. Zip Code <i>21215</i>		10g. Citizen of What Country? <i>UNITED STATES</i>															
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>-</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>MILL WORKER</i>			16b. Kind of Business/Industry <i>BALTIMORE SPICE COMPANY</i>															
17. Father's Name (First, Middle, Last) <i>JONAH SAVAGE</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>LILLIAN SAVAGE</i>																
19a. Informant's Name/Relationship (Type, Print) <i>KIM E. SMITH- DAUG.</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2808 RUSCOMBE LANE, BALTIMORE, MD 21215</i>																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>DRUID RIDGE CEMETERY</i>		Date		20c. Location - City or Town, State <i>7-25-97 PIKESVILLE, MD</i>														
21. Signature of Funeral Service Licensee <i>Sharon Stokes</i>						22. Name and Address of Facility <i>WM. C. MARCH FH.-4300 WABASH AVENUE</i>																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:50%;">e. <i>Pneumonia</i> Due to (or as a consequence of):</td> <td style="width:20%;">Approximate Interval Between Onset and Death <i>2 weeks</i></td> </tr> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 4em;">{</td> <td>b. <i>Laryngeal carcinoma</i> Due to (or as a consequence of):</td> <td><i>years</i></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>coronary artery disease</i> <i>atrial fibrillation</i></td> </tr> </table>											Immediate Cause (Final disease or condition resulting in death)	e. <i>Pneumonia</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>2 weeks</i>	{	b. <i>Laryngeal carcinoma</i> Due to (or as a consequence of):	<i>years</i>	c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>coronary artery disease</i> <i>atrial fibrillation</i>	
Immediate Cause (Final disease or condition resulting in death)	e. <i>Pneumonia</i> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>2 weeks</i>																				
{	b. <i>Laryngeal carcinoma</i> Due to (or as a consequence of):	<i>years</i>																				
	c. Due to (or as a consequence of):																					
	d. Due to (or as a consequence of):																					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>coronary artery disease</i> <i>atrial fibrillation</i>																					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred													
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)																			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																						
29b. Signature and title of certifier <i>Louis W. Miller</i>					29c. License number <i>D07421</i>		29d. Date signed (Month, Day, Year) <i>7/21/97</i>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Louis W. Miller, M.D. Evergreen Nursing & Rehab Center, Baltimore</i>																						
31. Date filed (Month, Day, Year) <i>JUL 22 1997</i>					32. Registrar's Signature <i>Julia Anderson-Randall</i>																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

State of Maryland / Department of Health and Mental Hygiene 97 22192

rja

Reg. No.

DHHM 16 Rev 6/95

William
Stiener

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

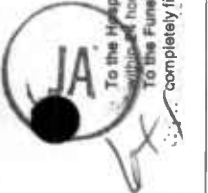
97 22193

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM J. STINER, III				2. Date of Death Month JULY Day 21, Year 1997		3. Time of Death 4:00AM	
	4a. Facility Name (If not institution, give street and number) 5719 EDMONDSON AVE.				4b. City, Town, or Location of Death CATONSVILLE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 213-09-8809		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) 12/22/1914	
	Usual Residence of Decedent		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location CATONSVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 5719 EDMONDSON AVE. APT. BB-6		10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSEMBLER		16b. Kind of Business/Industry WESTINGHOUSE			
	17. Father's Name (First, Middle, Last) WILLIAM JOSEPH STINER, II				18. Mother's Name (First, Middle, Maiden Surname) ANNA GRACE BACON			
	19a. Informant's Name/Relationship (Type, Print) EDITH M. STINER/ WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5719 EDMONDSON AVE. APT. BB-6 CATONSVILLE, MD 21228			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK		20c. Location - City or Town, State BALTIMORE, MD.		20d. Date 7/24/97	
	21. Signature of Funeral Service Licensee <i>Phillip Stach</i>				22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>Cancer of the Prostate</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death <u>6 years</u>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
State Registrar	29b. Signature and title of certifier <i>Patrick W. White</i>				29c. License number 023365		29d. Date signed (Month, Day, Year) 7/21/97	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Patrick W. White 716 Maiden Lane #205, Baltimore, MD							
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature <i>J. Davidson-Randall</i>						

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed without delay after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22194

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Joseph Sellars</u>				2. Date of Death Month <u>July</u> Day <u>15</u> Year <u>1997</u>		3. Time of Death <u>5:15 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Good Samaritan Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>215-10-8768</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>90</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Sept. 1, 1906</u>	
	9. Birthplace (State or Foreign Country) <u>North Carolina</u>		10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Baltimore</u>	
Usual Residence of Decedent								
10e. Street and Number <u>25 Lyndale Ave.</u>			10f. Zip Code <u>21236</u>			10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Head Machinist</u>		
17. Father's Name (First, Middle, Last) <u>James S. Sellars</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Claudia A. Wells</u>			16b. Kind of Business/Industry <u>Newspaper</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Jody Sellars</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>25 Lyndale Ave., Baltimore, MD 21236</u>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Graham Memorial Cemetery</u>			20c. Location - City or Town, State <u>Orange, VA</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>			22. Name and Address of Facility <u>ALTENBURG FUNERAL HOME, P.A.</u> <u>6009 Harford Rd., Baltimore, MD 21214</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) a. <u>Massive Intracerebral bleed</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <u>five days</u>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>Jihad Yousef, MD</u>			29c. License number <u>P10584</u>			29d. Date signed (Month, Day, Year) <u>July 15, 1997</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Jihad Yousef, MD</u> <u>Good Samaritan Hospital 5601 Loch Raven Boulevard, Baltimore, M.D. 21239</u>								
31. Date filed (Month, Day, Year) <u>JUL 22 1997</u>			32. Registrar's Signature <u>J. Davidson-Randall</u>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

REF 20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22195

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

James

2. Date of Death

Month
JulyDay
15Year
1997

3. Time of Death

8:25 pm

4a. Facility Name (If not institution, give street and number)

JOSEPH RICHIE HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

218-10-6444

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

09/05/1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2507 ELSINORE AVENUE

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Security Officer

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

THOMAS SCOTT

18. Mother's Name (First, Middle, Maiden Surname)

SUSIE SCOTT

19a. Informant's Name/Relationship (Type, Print)

JAMES SCOTT, JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2507 ELSINORE AVENUE, BALTO., MD 21216

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

7/21 Garrison Forest Veteran Cem. Owings Mills, MS

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Leroy O. Dyett

22. Name and Address of Facility

LEROY O. DYETT & SON FUNERAL HOME, P.A.
4600 LIBERTY HEIGHTS AVE., BALTO. 21207

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Respiratory Arrest

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes.

b.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c.

Metastasis to Bone

Due to (or as a consequence of):

6 mos

d.

Carcinoma Prostate

2 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☒ Other (Specify)

Hospice

27. Manner of Death

☐ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert C. Irwin MD

29c. License number

D08900

29d. Date signed (Month, Day, Year)

7-17-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert C. Irwin MD 828 N. Eutaw St. Baltimore MD 21201

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22196

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD L STEPP

2. Date of Death

Month Day Year
JULY 15 1997

3. Time of Death

16:27

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

281-32-6693

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 14, 1937

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

738 Pleasant Hill Road

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4or 5+)
216a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Artist

16b. Kind of Business/Industry

Artist

17. Father's Name (First, Middle, Last)

Tilden Stepp

18. Mother's Name (First, Middle, Maiden Surname)

Olga Trivett

19a. Informant's Name/Relationship (Type, Print)

Nancy Stepp (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

738 Pleasant Hill Rd. Ellicott City, MD 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Carroll Cremation, Inc.

Date

July 17, 1997

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

Robert Eugene Buhner

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin Knolls Rd. Columbia, MD 2104523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Atherosclerotic Cardiovascular Disease

Approximate
Interval Between
Onset and Death

years.

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery By Pass Surgery x 2

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert Eugene Buhner Deputy ME

29c. License number

D31473

29d. Date signed (Month, Day, Year)

July 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICE A TOJE, MD 4565 HEMLOCK CONG WAY ELLICOTT CITY MD 21042

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22197

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary A. Scott				2. Date of Death Month July Day 16 Year 1997				3. Time of Death 8:12 a.m.					
	4a. Facility Name (If not institution, give street and number) Stella Maris				4b. City, Town, or Location of Death Baltimore County				4c. County of Death Baltimore					
Funeral Director	5. Social Security Number 220-40-8307		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) September 12, 1902		9. Birthplace (State or Foreign Country) Ireland	
	Usual Residence of Decedent													
10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 64 East Broadway				10f. Zip Code 21014				10g. Citizen of What Country? USA						
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook				16b. Kind of Business/Industry Baltimore County Schools						
17. Father's Name (First, Middle, Last) Martin Glynn								18. Mother's Name (First, Middle, Maiden Surname) Mary Anne MacDermott						
19a. Informant's Name/Relationship (Type, Print) Jerome A. Meusel (Brother -in -law)								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 64 E. Broadway Bel Air, Maryland 21014						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National Cemetery July 18, 1997 Baltimore, Maryland				Date		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee Brother Joseph Chynocki				22. Name and Address of Facility E.F. Lassahn Funeral Home, Inc. 11750 Belair Road Kingsville, Maryland 21087-1351										
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier [Signature]				29c. License number D25686				29d. Date signed (Month, Day, Year) 7-16-97						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABRAHAM IPAKCHI 7600 OSCAR DRIVE BALTIMORE MD 21207														
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature [Signature]										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

B.K.S.

UNKNOWN 97-157

BRECK STEPHEN STOVALL

Items: 23a part 1, 27, 28a-f per MEO G-749 7/23/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22198

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BRECKE STEPHEN STOVALL

2. Date of Death

Month JULY Day 16, Year 1997

3. Time of Death

0432AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

900BLK. SOUTH MONROE STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

219-74-2619

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

34 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

1-20-63

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

823 EXETER HALL AVE

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

16

Collage (1-4 or 5+)

Collage

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unemployed

16b. Kind of Business/Industry

Odd Jobs

17. Father's Name (First, Middle, Last)

CLEVELAND WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

MARY STOVALL

19a. Informant's Name/Relationship (Type, Print)

SISTER
QUAWANDRA BROWN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

823 EXETER HALL AVE, BALTO, MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CEMETORY

Date

7/22/97

20c. Location - City or Town, State

BALTO, MD.

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

1639 N. Broadway BALTO, MD 21213
JEFF MILLER P.C. FUNERAL HOME & SERVICE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. COCAINE AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

FIELD

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

found 7/16/97

28b. Time of Injury

found 4:25^M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found near roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State) 900 Block S. Monroe St. Baltimore, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David R Fowler

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 16, 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

EDWARD JACOB SMITH

2. Date of Death

JULY 19 1997

3. Time of Death

8:03PM

4a. Facility Name (If not institution, give street and number)

PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

5. Social Security Number

217-60-6606

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 27, 1943

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

CHARLES

10c. City, Town or Location

LA PLATA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

139 WEST QUAIL LANE

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

COMMUNICATIONS AT&T

17. Father's Name (First, Middle, Last)

STEPHEN SMITH

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET HETTERICK

19a. Informant's Name/Relationship (Type, Print)

JOYCE SMITH/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

139 WEST QUAIL LANE LA PLATA, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Gardens of Faith CEMETERY

Date

7/23/97

20c. Location - City or Town, State

ROSSVILLE, MD

21. Signature of Funeral Service Licensee

per VR

22. Name and Address of Facility

CONNELLY FUNERAL HOME of ESSEX
300 MACE AVE, BALTIMORE, MD 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ACUTE MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

MINUTES

Due to (or as a consequence of):
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

YEARS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

D46419

29d. Date signed (Month, Day, Year)

11/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charlene A. Letchford, M.D. 404 E. Charles St. La Plata, MD 20646

State
Registrar

31. Date filed (Month, Day, Year)

NOV 07 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22200

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET, H. TURNER				2. Date of Death Month July Day 20 Year 1997		3. Time of Death 17:52 pm	
	4a. Facility Name (If not institution, give street and number) Liberty Medical Center 2600 Liberty Heights Baltimore, MD 21215				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death n/a	
Funeral Director	5. Social Security Number 195--12-4731		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) JUL. 9, 1922	
	9. Birthplace (State or Foreign Country) ATLANTIC, NJ		10a. State MD		10b. County n/a		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1818 N. APPLETON STREET		10f. Zip Code 21217		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER - INSPECTOR		16b. Kind of Business/Industry WESTERN ELECTRIC CO			
	17. Father's Name (First, Middle, Last) JOHN R. HARGROVE		18. Mother's Name (First, Middle, Maiden Surname) GEORGINE MARLEY		19. Informant's Name/Relationship (Type, Print) RICHARD E. TURNER- Hus.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1818 N. APPLETON STREET, BALTIMORE, MD # 17	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON F OREST VA CEM.		20c. Location - City or Town, State 7-26-97 OWINGS MILLS, MD		20d. Date	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility WM. C. MARCH FH. 4300 WABASH AVENUE		23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration		Approximate Interval Between Onset and Death 30 minutes	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
Medical Certification: To Be Completed by Physician/Medical Examiner	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D17031	
	29d. Date signed (Month, Day, Year) July 20, 1997		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KWANG N. Kim, M.D. 2600 Liberty Medical Center, Baltimore, MD 21215		31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature <i>[Signature]</i>	
	33. State Registrar							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

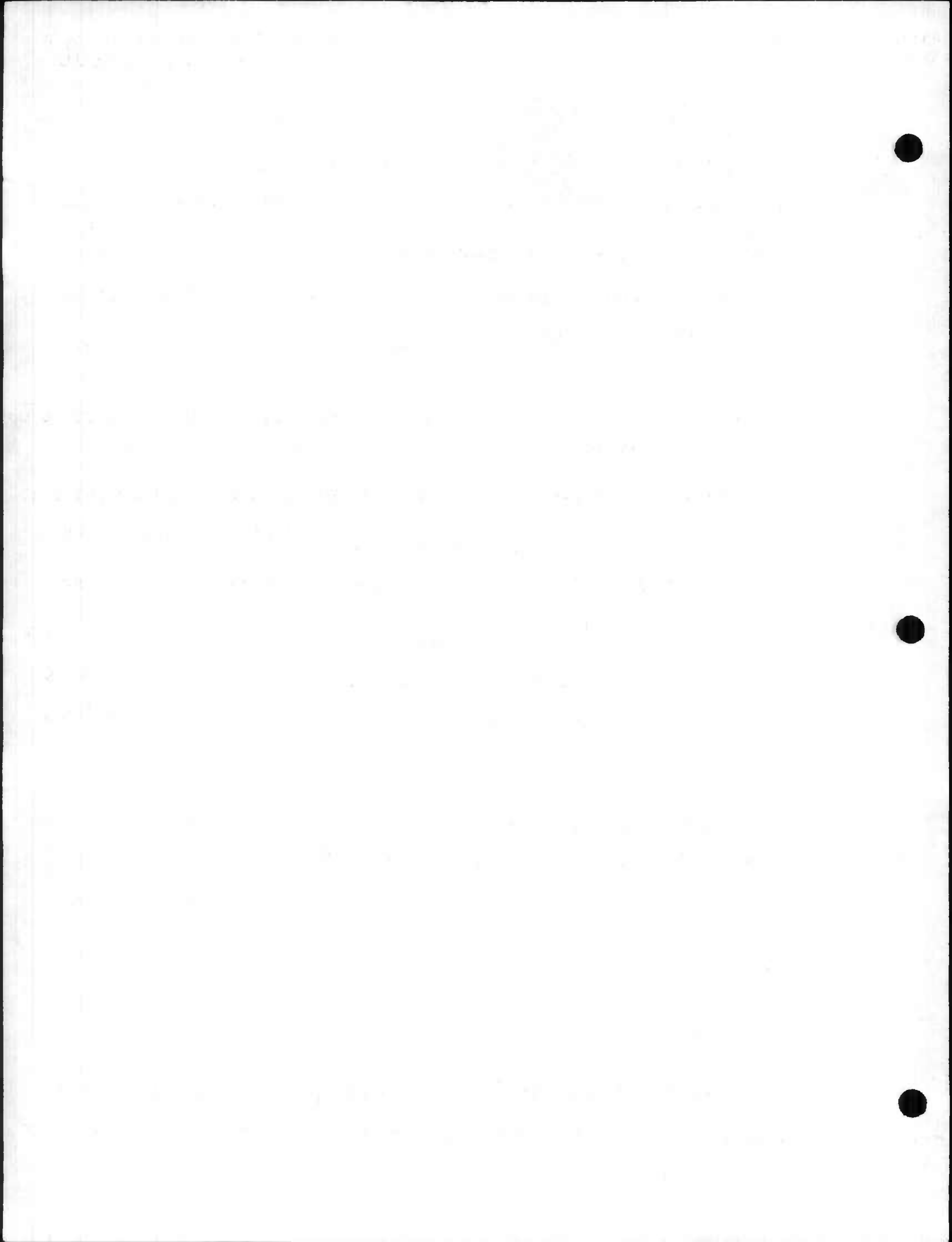
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22201

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Lee Taylor

2. Date of Death

Month

Day

Year

7

17

97

3. Time of Death

5:30 AM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

521 OAKLAND AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

212-78-5618

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

34 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

9-4-62

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

521 OAKLAND AVE

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 09-7-83

11-12-91

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chemical Specialist

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Lyman King

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Bethea

19e. Informant's Name/Relationship (Type, Print)

Carrie Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

521 OAKLAND AVE Balto. Md. 21212

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veteran Cemetery

Date

7/22/97

20c. Location - City or Town, State

Owings Mill, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Jeff Miller P.C.F./H

1639 N. B Roadway

Balto. Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Severe hypoxia

Due to (or as a consequence of):

1 mon

b. CMV pneumonitis

Due to (or as a consequence of):

1 mon

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Chronic Renal insufficiency

Due to (or as a consequence of):

2 yrs

d. AIDS

Due to (or as a consequence of):

3 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

H/o pneumocystis, MAI bacteremia

MRSA, Severe anemia, hpo Calceinia

hpo Kalamia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D13848

29d. Date signed (Month, Day, Year)

7/21/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Philip A. Mackowiak, MD Balto. VAMC 10 N. Greene Street, 21221

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

T

101 11 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22202

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH SPENCER JANNEY VEALE

2. Date of Death

Month Day Year
July 17, 1997

3. Time of Death

4:30 PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

12750 Greenspring Ave.

4b. City, Town, or Location of Death

Owings Mills

4c. County of Death

Baltimore

5. Social Security Number

219-16-9430

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
05-12-1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12750 Greenspring Ave.

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Stuart Symington Janney

18. Mother's Name (First, Middle, Maiden Surname)

Frances Spencer

19e. Informant's Name/Relationship (Type, Print)

Frances V. Horich (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3204 Caves Rd., Owings Mills, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Thomas-Garrison

Date

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

James R. Kehr

22. Name and Address of Facility

Henry W. Jenkins & Sons Co.

4905 York Rd., Baltimore, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia, end stage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia, hyponatremia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

David G. Roberts

29c. License number

D34988

29d. Date signed (Month, Day, Year)

7-18-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David G. Roberts, M.D. 10755 Falls Rd., Lutherville, Md. 21093

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Gordon-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22203

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK VINCI				2. Date of Death Month July Day 18 Year 1997		3. Time of Death 2:30 A.M.	
	4e. Facility Name (If not institution, give street and number) Gilcrest Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-07-9500		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 7, 1912	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 17 Juliet Lane, Unit 204				10f. Zip Code 21236		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collage (1-4 or 5+) 			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner			16b. Kind of Business/Industry Stone Quarry	
	17. Father's Name (First, Middle, Last) Joseph A. Vinci				18. Mother's Name (First, Middle, Maiden Surname) Maria (unknown)			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Helen Vinci				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Juliet Lane, Unit 204, Baltimore, MD 21236			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns.		Date 7/19/97	20c. Location - City or Town, State Timonium, MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. s/p multiple CVA Due to (or as a consequence of): b. Dementia Due to (or as a consequence of): c. Failure to Thrive Due to (or as a consequence of): d. 							
	Approximate Interval Between Onset and Death e. 2 yrs b. 2 yrs c. 6 mo d. 							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Inpt Gilcrest						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D47707		29d. Date signed (Month, Day, Year) July 18, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITA PABLA MD 6565 North Charles St Ste 203 Baltimore, MD 21204								
31. Date filed (Month, Day, Year) JUL 22 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22204

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herbert Vandroff						2. Date of Death Month Day Year July 18 1997		3. Time of Death 8:10 AM	
	4a. Facility Name (If not Institution, give street and number) Genesis Elder Care						4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 248-44-2317		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) June 3, 1929		9. Birthplace (State or Foreign Country) S.C.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County A.A.CO.		10c. City, Town or Location SEVERN				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 421 QUEENSTOWN ROAD				10f. Zip Code 21144		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFRO AMERICAN			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER				16b. Kind of Business/Industry R.H. SHOOK CO.			
	17. Father's Name (First, Middle, Last) JAMES VANDROFF						18. Mother's Name (First, Middle, Maiden Surname) ROSIE VANDROFF			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) BEATRICE BERRY FRIEND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10006 VILLAGE GREEN DR. WOODSTOCK, MD. 21163					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM.		Data 7/23/97		20c. Location - City or Town, State LANSDOWNE, MD.			
	21. Signature of Funeral Service Licensee Paul A. Estep				22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RETROMOLAR TRIGONE CANCER Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Shelley M. Cabbell, M.D.		29c. License number D38708		29d. Date signed (Month, Day, Year) 7/18/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHELLEY M. CABBELL 4000 OLD COURT ROAD, BALTIMORE, MD 21208										
State Registrar	31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature John Davidson-Randall					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LISA DOREEN WRIGHT-BEY				2. Date of Death Month Day Year JULY 10, 1997		3. Time of Death 0654 AM	
	4a. Facility Name (If not institution, give street and number) 4107 PARK HEIGHTS AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 259-25-5126		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 36 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 27, 1961	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 2713 OSWEGO AVE		10f. Zip Code 21215	
	10g. Citizen of What Country? USA				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) SECRETARY	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY				16b. Kind of Business/Industry PRIVATE BUSINESS		17. Father's Name (First, Middle, Last) GEORGE BEY	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) CHRISTINE BASKERVILLE				19a. Informant's Name/Relationship (Type, Print) LAWANNA SHERROD / SISTER			
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2627 QUANTICO AVE BALTIMORE, MARYLAND 21215				20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) GREENMOUNT CREMATORIUM				20c. Location - City or Town, State BALTIMORE, MD		20d. Date 7/18/97	
	21. Signature of Funeral Service Licensee Sam Harris				22. Name and Address of Facility CHATHAM HARRIS & SONS 3240 REISTERSTOWN ROAD BALTIMORE, MARYLAND 21215			
To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. UNDETERMINED Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) found 7/10/97			
	28b. Time of Injury found 7:15 PM				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred unknown				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in basement			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 4107 Park Heights Avenue, Baltimore, Maryland				29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Sam Harris				29c. License number O.C.M.E			
	29d. Date signed (Month, Day, Year) JULY 10, 1997				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201			
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature Julia Davidson-Randall			
	33. State Registrar State Registrar							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

SHIRLEY WILLIAMS

97 22206

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHIRLEY WILLIAMS				2. Date of Death Month JULY Day 17 Year 1997		3. Time of Death 2:05 AM	
	4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 238-26-4945	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 3, 1937		9. Birthplace (State or Foreign Country) VIRGINIA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2013 CLIFTON AVENUE			10f. Zip Code 21217		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) GEORGE OLIVER				18. Mother's Name (First, Middle, Maiden Surname) MARY SMITH			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gerold E. Williams / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 Clifton Avenue Baltimore, Md 21217			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date 7/22/97		20c. Location - City or Town, State Baltimore, Md	
	21. Signature of Funeral Service Licensee Gregory Harris				22. Name and Address of Facility CHATHAM - HARRIS F.H. 3340 REISTERSTOWN ROAD BALTIMORE, MD 21215			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
24a. Was an autopsy performed? partial <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Dennis J. Chute, MD				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 17, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature Julia Burdson-Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.


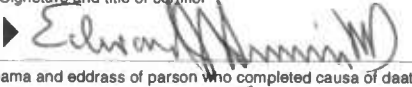

Medical Certification: To Be Completed by Physician/Medical Examiner

3
State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22207

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Clementine Williams				2. Date of Death Month: July Day: 15 Year: 1997		3. Time of Death 7:30 am		
	4a. Facility Name (If not institution, give street and number) 406 S. Poppleton Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City		
Funeral Director	5. Social Security Number 220-14-7579		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		6. Data of Birth (Month, Day, Year) June 4, 1911		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		
Usual Residence of Decedent									
10e. Street and Number 406 S. Poppleton Street			10f. Zip Code 21223			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: white			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress			
16b. Kind of Business/Industry Food Service			17. Father's Name (First, Middle, Last) unknown			18. Mother's Name (First, Middle, Maiden Surname) unknown			
19a. Informant's Name/Relationship (Type, Print) Jesse J. Williams, son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6503 Mountain Dale Road, Thurmont, MD 21788						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park			Data 7/18/97		20c. Location - City or Town, State Elkridge, MD	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Gary L. Kaufman Funeral Homes 7250 Washington Blvd., Elkridge, MD 21075						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Cardiac Arrest</p> <p>b. Malnutrition and Chronic Infection</p> <p>c. Decubitus Ulcer</p> <p>d. </p> </div> <div style="width: 65%;"> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> </div>									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Regenerative Joint Disease									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) N/A		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)			29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier  Medical Director			29c. License number 005207			29d. Date signed (Month, Day, Year) 7/18/97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Edward J. Hinman MD 2305 N. Charles St., Balto., Md.									
31. Date filed (Month, Day, Year) JUL 22 1997			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22208

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lorna W. Waters				2. Date of Death Month Day Year July 21 1997		3. Time of Death 12:25AM		
	4e. Facility Name (If not institution, give street and number) North Oaks Retirement Center				4b. City, Town, or Location of Death Pikesville		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-14-8982		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) June 11 1921		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Pikesville		
Usual Residence of Decedent									
10a. State Md.			10b. County Baltimore			10c. City, Town or Location Pikesville			
10e. Street and Number 725 Mt. Wilson Lane			10f. Zip Code 21208			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Capt. John G. Waller			18. Mother's Name (First, Middle, Maiden Surname) Margaret Murray						
19a. Informant's Name/Relationship (Type, Print) Mr. John Waters/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7304 Oskaloosa Dr. Rockville, MD. 20855						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery			20c. Location - City or Town, State Pikesville, MD.		20d. Date 7-23-97	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)									
a. <u>Renal Failure</u> Due to (or as a consequence of):									
b. <u>Hypertension</u> Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Stroke</u>									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined									
28a. Date of Injury (Month, Day, Year)									
28b. Time of Injury M									
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
28d. Describe how injury occurred									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 									
29c. License number D38675									
29d. Date signed (Month, Day, Year) 7/21/97									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL MESHULAM 1147 S HANOVER ST BALTIMORE MD 21230									
31. Date filed (Month, Day, Year) JUL 22 1997									
32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22209

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Joseph Weinzirl

2. Date of Death

Month Day Year
July 11, 1997

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

2345 Searles Road

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-14-1691

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 9, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2345 Searles Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: Korean13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7 Years

Collage (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Carpentry

17. Father's Name (First, Middle, Last)

William Weinzirl

18. Mother's Name (First, Middle, Maiden Surname)

Caroline M. Hesse

19e. Informant's Name/Relationship (Type, Print)

Janice F. Weinzirl/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2345 Searles Road Baltimore, Maryland 21222

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest U.A. Cem 7/14/97 Owings Mills, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Avenue Baltimore, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Dilated Cardiomyopathy

Due to (or as a consequence of):

2 years

c. Coronary Artery Disease

Due to (or as a consequence of):

4 years

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28e. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D51185

29d. Date signed (Month, Day, Year)

7/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Colleen Christmas MD, 5505 Hopkins Bayview Circle, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

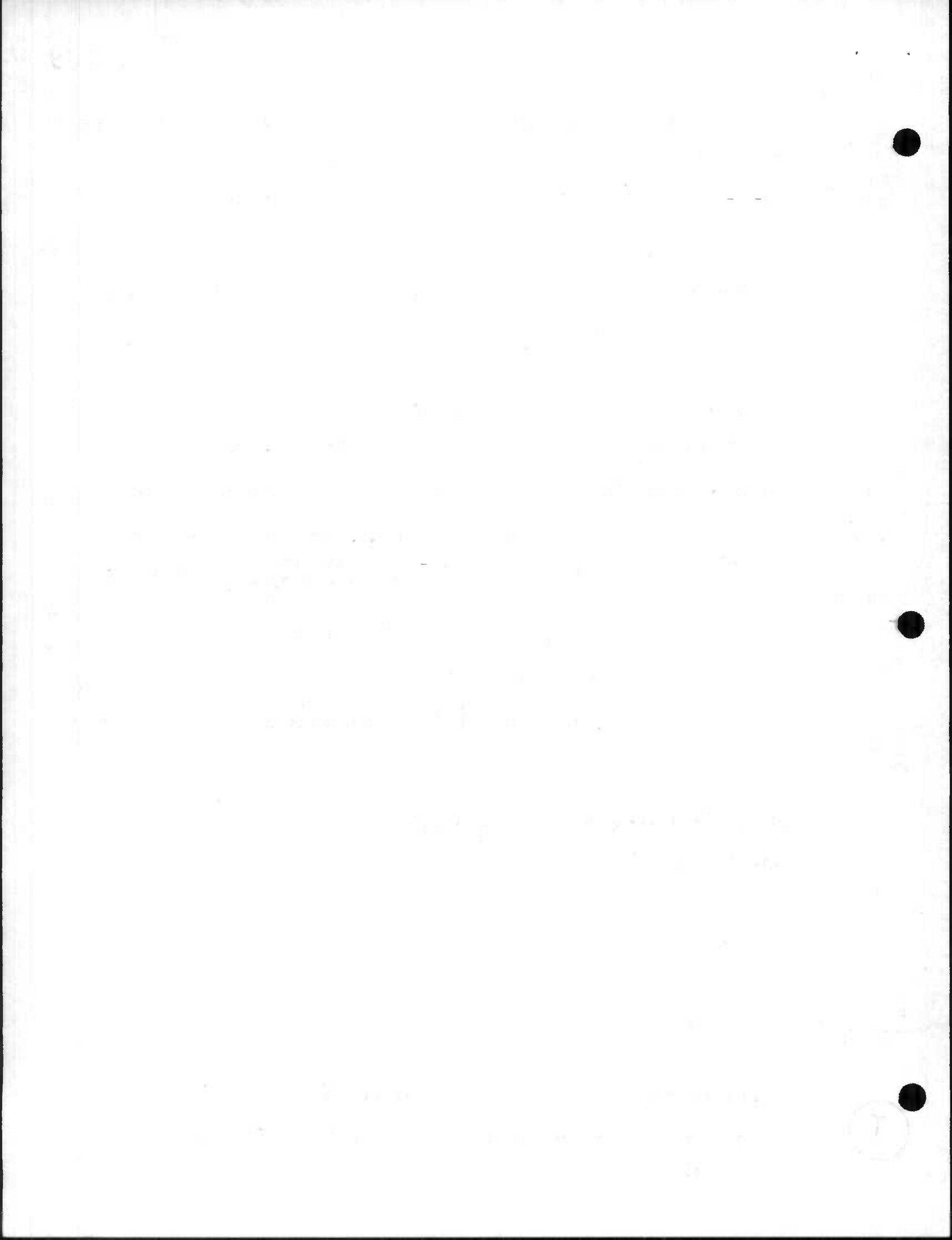
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22210

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA WEINLICH				2. Date of Death Month July , Day 18 , Year 1997		3. Time of Death 5:50 hrs.																														
	4a. Facility Name (If not institution, give street and number) CATONSVILLE COMMONS NURSING HOME				4b. City, Town, or Location of Death CATONSVILLE		4c. County of Death BALTIMORE																														
Funeral Director	5. Social Security Number 217-14-5513		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN 14, 1907	9. Birthplace (State or Foreign Country) MARYLAND																													
	Usual Residence of Decedent																																				
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																													
	10e. Street and Number 775 W. CROSS STREET				10f. Zip Code 21230		10g. Citizen of What Country? U.S.A.																														
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TELLER		16b. Kind of Business/Industry MARYLAND NATIONAL BANK																														
	17. Father's Name (First, Middle, Last) LOUIS WEINLICH				18. Mother's Name (First, Middle, Maiden Surname) MAMIE KROGMAN																																
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) KATHLEEN GALLION (NIECE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1903 OAK LODGE ROAD - CATONSVILLE, MD. 21228																																
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY CROSS CEMETERY		Date 7/21/97		20c. Location - City or Town, State BALTIMORE, MD																														
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229																																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																				
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="7">e. Acute myocardial infarction Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">{</td> <td colspan="7">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. Acute myocardial infarction Due to (or as a consequence of):							{	b. Due to (or as a consequence of):							c. Due to (or as a consequence of):							d. Due to (or as a consequence of):					
Immediate Cause (Final disease or condition resulting in death)	e. Acute myocardial infarction Due to (or as a consequence of):																																				
	{	b. Due to (or as a consequence of):																																			
		c. Due to (or as a consequence of):																																			
		d. Due to (or as a consequence of):																																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus Hypertensive Cardiovascular disease Thrombocytopenia. Dementia						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																															
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																															
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred																																	
28f. Location (Street and Number or Rural Route Number, City or Town, State)																																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																					
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D18362		29d. Date signed (Month, Day, Year) July, 18, 1997																															
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. KOMAL DANG 3455 WILKENS AVENUE - BALTIMORE, MD 21229																																					
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature <i>[Signature]</i>																																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

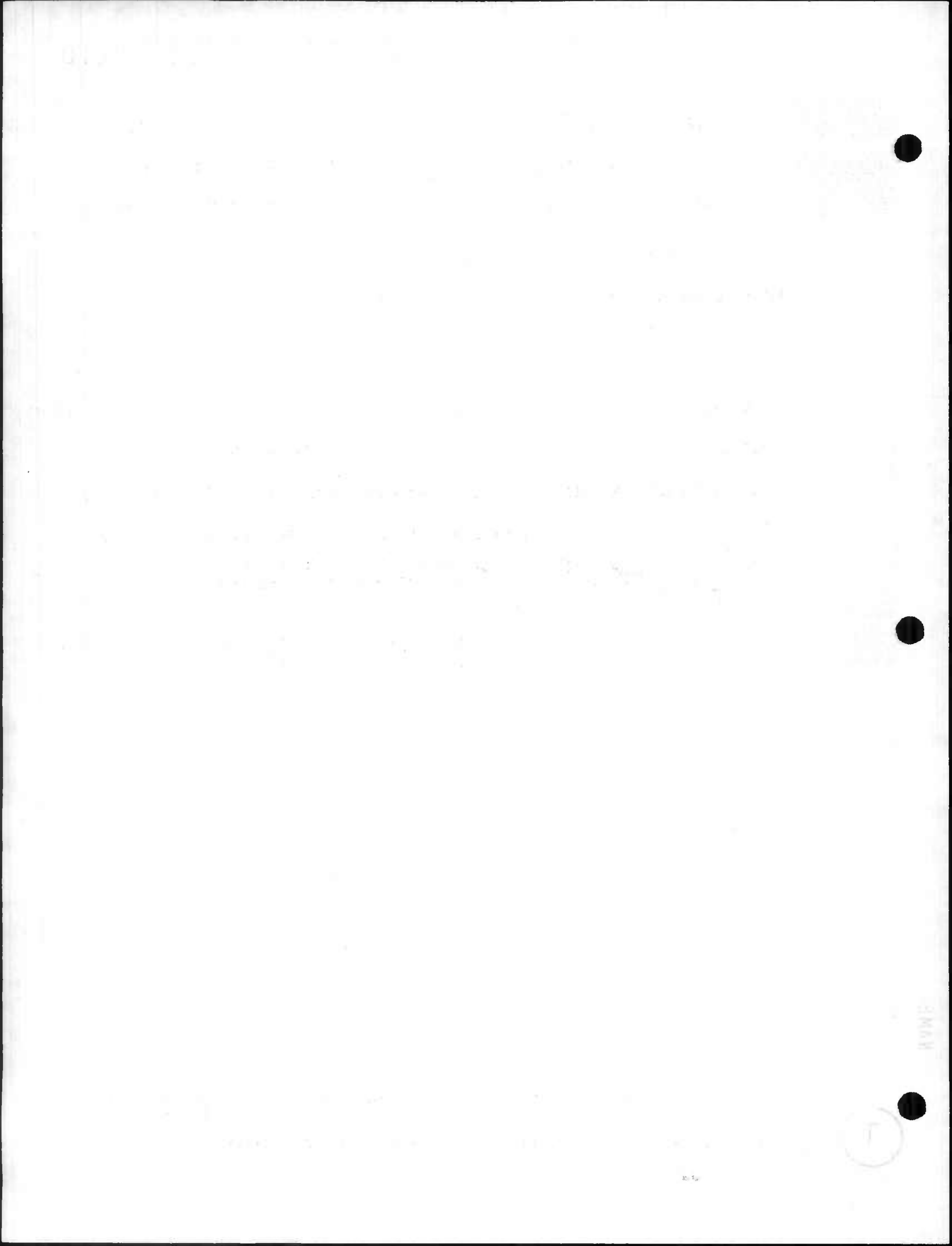
NAME: Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

T



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22211

ITEM#20b FLM#G749 7/22/97 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lula Marie Watkins Young

2. Date of Death

Month Day Year
July 17, 1997

3. Time of Death

4:00 A.M.

4a. Facility Name (If not institution, give street and number)

8631 Willow Oak Road

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore County

5. Social Security Number

213-58-4140

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 15, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8631 Willow Oak Road

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4or 5+)

4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Booker Scriven

18. Mother's Name (First, Middle, Maiden Surname)

Mary Theresa Geldmacher

19a. Informant's Name/Relationship (Type, Print)

James L. Young, Jr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8631 Willow Oak Road, Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery 7/19/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Juanita R Thomas

22. Name and Address of Facility

John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cholangiocarcinoma
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Weiner M.D.

29c. License number

D26475

29d. Date signed (Month, Day, Year)

7/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. George Weiner 9512 Harford Rd. Balto. Md

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director; page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

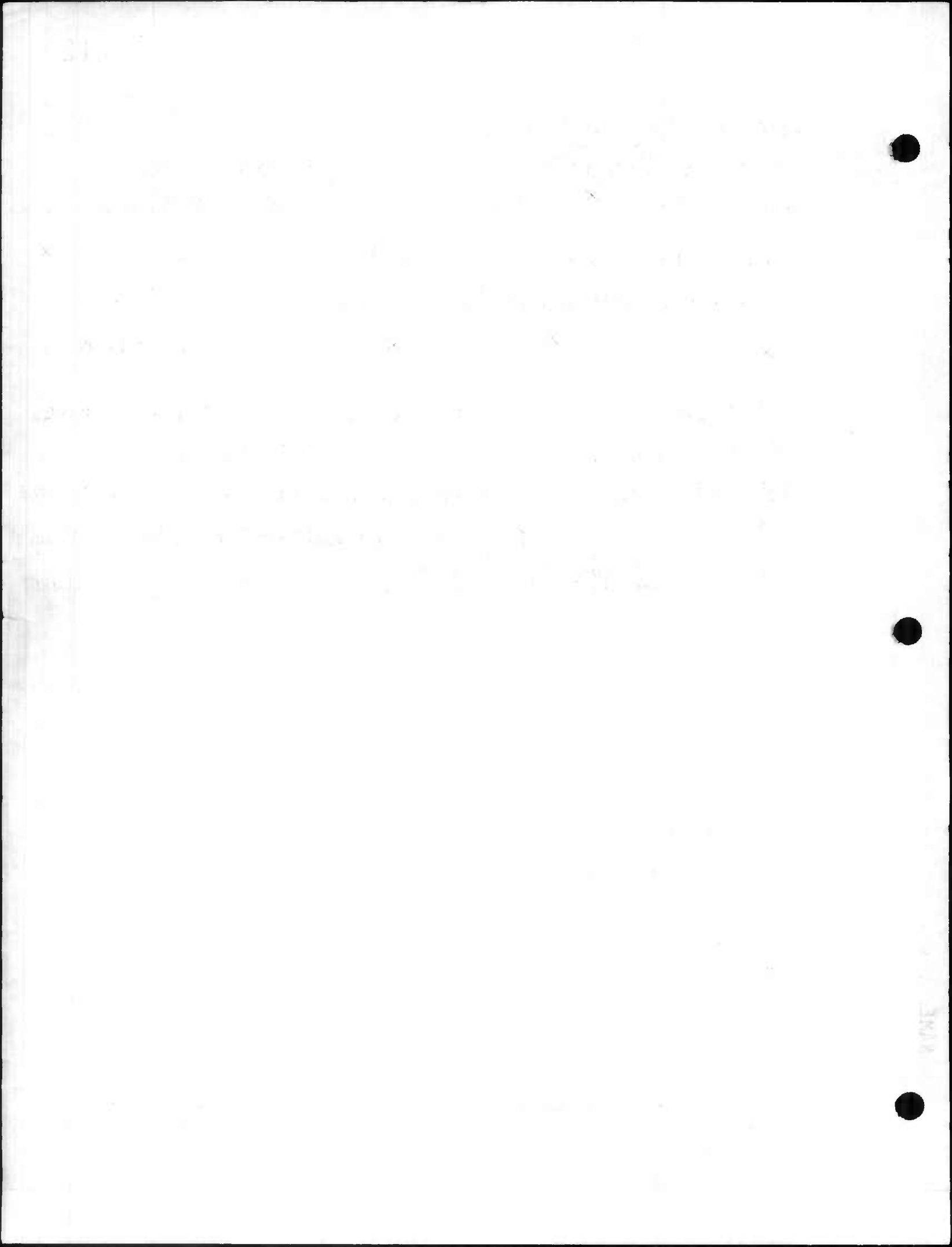
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22212

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annie Mae Anderson				2. Date of Death Month Day Year JULY 16 1997		3. Time of Death 6900
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 248-32-9342	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 12, 1924	
	9. Birthplace (State or Foreign Country) South Carolina						
To Be Completed by Funeral Director	10a. State md.		10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 98 Smithwood Avenue, Baltimore, Md.			10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th grade College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry Private Homes		
	17. Father's Name (First, Middle, Last) Zack Pearson			18. Mother's Name (First, Middle, Maiden Surname) Lucille Clark			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Blondell Powell			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Turk Garth, Catonsville, Maryland 21228			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 7-19-97 Randallstown, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home, PA. 2142 N. Fulton Avenue, Baltimore, Maryland 21217			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. PULMONARY EDEMA Due to (or as a consequence of): 12 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. ASCVD Due to (or as a consequence of): 10 years c. Due to (or as a consequence of): d.						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease Diabetes mellitus						
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier 		29c. License number D22648		29d. Date signed (Month, Day, Year) July 16, 1997		
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jerome I. SNYDER M.D. 900 SOUTH CATON AVENUE BALTIMORE, MARYLAND						
	31. Date filed (Month, Day, Year) JUL 23 1997		32. Registrar's Signature 				



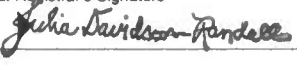


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22213

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) STELLA BALSARICK				2. Date of Death Month July Day 22 Year 1997		3. Time of Death 1:50am									
	4a. Facility Name (If not institution, give street and number) Johns Hopkins University Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A									
Funeral Director	5. Social Security Number 220-05-7395		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06/08/1920	9. Birthplace (State or Foreign Country) Maryland								
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
	10e. Street and Number 405 S. Duncan Street				10f. Zip Code 21231		10g. Citizen of What Country? USA									
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		Collage (1-4or 5+) Housewife		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Domestic									
	17. Father's Name (First, Middle, Last) Joseph Janiuk				18. Mother's Name (First, Middle, Maiden Surname) Mary Unknown											
	19a. Informant's Name/Relationship (Type, Print) Victor J. Balsarick SR/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 S. Duncan Street Baltimore, Maryland 21231											
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oaklawn		Date 7/24/97		20c. Location - City or Town, State Baltimore, Maryland									
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility David J. Weber Funeral Home 401 S. Chester St. Baltimore, Maryland 21231											
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Multi System Organ failure Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 1 week</td> </tr> <tr> <td>b. Metastatic Bladder Carcinoma Due to (or as a consequence of):</td> <td>12 month</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Multi System Organ failure Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 week	b. Metastatic Bladder Carcinoma Due to (or as a consequence of):	12 month	c. _____ Due to (or as a consequence of):		d. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Multi System Organ failure Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 week														
	b. Metastatic Bladder Carcinoma Due to (or as a consequence of):	12 month														
	c. _____ Due to (or as a consequence of):															
	d. _____ Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Urinary tract Infection Diabetes Atrial fibrillation						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
				28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number 76120		29d. Date signed (Month, Day, Year) July 22 1997										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William T. Tseng, MD JHBMC 4940 Eastern Ave Baltimore MD 21224																
31. Date filed (Month, Day, Year) JUL 23 1997		32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22214

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD JOSEPH BREMER

2. Date of Death

Month Day Year
July 16 1997

3. Time of Death

1:35AM

4a. Facility Name (If not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

369-28-6781

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
March 11, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9535 Beach Park Street

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+ years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Proofreader

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Edward Francis Bremer

18. Mother's Name (First, Middle, Maiden Surname)

Ottilia Abele

19a. Informant's Name/Relationship (Type, Print)

Gregory Bremer (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2317 Furnace Road, Fallston, MD. 21047

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Green Mount Crematory

Date

7/18/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. acute congestive heart failure onset

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

c. acute gangrene of left leg months

Due to (or as a consequence of):

d. peripheral vascular disease years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D13339

29d. Date signed (Month, Day, Year)

MD 7/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TETIANE HENRY 8824 Cunningham Dr. Berwyn Heights

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22215

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Tyrone Blackwell, Sr.		2. Date of Death Month Day Year JULY 19, 1997		3. Time of Death 0810 AM
	4a. Facility Name (If not institution, give street and number) 1958 PEARLMAN PLACE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA
Funeral Director	5. Social Security Number 219-66-5456	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 09-06-56		9. Birthplace (State or Foreign Country) Md.		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Md.		10b. County NA
	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 1753 Cliftview Avenue		10f. Zip Code 21213		10g. Citizen of What Country? USA
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) NA		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter		16b. Kind of Business/Industry in & out of homes		
	17. Father's Name (First, Middle, Last) John L. Graves		18. Mother's Name (First, Middle, Maiden Surname) Delores Blackwell		
	19e. Informant's Name/Relationship (Type, Print) Gwendolyn Lopez		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 1753 Cliftview Avenue Baltimore, Maryland		
	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		20c. Location - City or Town, State 07-24-97 Dundalk, Md.
	21. Signature of Funeral Service Licensee <i>Frederic M. Smith</i>		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia				Approximate Interval Between Onset and Death
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i>		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) JULY 19, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JUL 23 1997		32. Registrar's Signature <i>John Davidson-Randall</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22216

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John R. Burl Jr.

2. Date of Death

Month

Day

Year

3. Time of Death

11:23 A.M.

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

Anne Arundel

5. Social Security Number

213 30 5139

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 23, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Annes

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

103 Davidson Road

10f. Zip Code

21666

10g. Citizen of What Country?

U.S.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Inspector

16b. Kind of Business/Industry

City of Baltimore

17. Father's Name (First, Middle, Last)

John R. Burl Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Kane

19a. Informant's Name/Relationship (Type, Print)

Mark Burl / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

224 Carvel Road Pasadena, Maryland 21122

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

Date

7/19/97

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Donna Brancowski

22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ventricular Fibrillation

Due to (or as a consequence of):

b.

Coronary ARTERY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

Inpatient

2 ER/Outpatient

3 DOA

Other:

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D43977

29d. Date signed (Month, Day, Year)

July 17 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Amber ORETUNO, 301 Hospital Drive, Glen Burnie, MD. 21061

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John Davidson-Randall

State Registrar

JOHN R. BURL, JR.
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22217

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ODELIA BROWN			2. Date of Death Month JULY Day 18 Year 1997		3. Time of Death 7:30 PM		
	4a. Facility Name (If not institution, give street and number) MD BAPTIST HOME FOR THE AGED			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 220-03-4580		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) FEBRUARY 18, 1911	
	9. Birthplace (State or Foreign Country) VIRGINIA		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1836 W. FAIRMOUNT AVENUE		10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3RD GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC WORKER		16b. Kind of Business/Industry OWN HOME		17. Father's Name (First, Middle, Last) NATHANIEL JEFFERSON	
	18. Mother's Name (First, Middle, Maiden Surname) LUCY BURGER		19a. Informant's Name/Relationship (Type, Print) ANNABELLE V. DUCKETT/NIECE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1836 W. FAIRMOUNT AVE., BALTIMORE, MARYLAND 21223		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) ROLLING GREEN CEMETERY		20c. Location - City or Town, State 7-24-97 WEST CHESTER, PENNSYLVANIA		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVENUE, BALTIMORE, MARYLAND 21217	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. acute myocardial infarction suspected Due to (or as a consequence of): b. Atherosclerotic heart disease Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Diabetes mellitus		Approximate Interval Between Onset and Death 10 minutes 5 hrs 10 yrs 10 yrs		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
	29c. License number D 30494		29d. Date signed (Month, Day, Year) 7/20/97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR DEBRA M. HAGG 4660 Wilkins Ave Baltimore MD 21229		31. Date filed (Month, Day, Year) JUL 23 1997	
State Registrar		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

... ..

... ..

... ..

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22218

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN EDGAR BELL				2. Date of Death Month JULY Day 16 Year 1997		3. Time of Death UNKNOWN	
	4a. Facility Name (If not institution, give street and number) 2524 HARFORD ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 250-10-0632		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 115 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 10, 1881	9. Birthplace (State or Foreign Country) FLORIDA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2524 HARFORD ROAD				10f. Zip Code 21218		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN Collega (1-4or 5+) UNKNOWN				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COMMUNITY SERVICE WORKER		16b. Kind of Business/Industry URBAN RENEWAL	
	17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ETHEL JOHNSON (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2524 HARFORD ROAD, BALTIMORE, MD. 21218			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. Date 7-22-97		20d. Location - City or Town, State LANSDOWNE, MARYLAND	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVENUE, BALTIMORE, MD. 21217			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Ventricular arrhythmia Due to (or as a consequence of):</p> <p>b. Atherosclerotic cardiovascular disease Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>10 years</p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D23399		29d. Date signed (Month, Day, Year) July 22, 1997		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Brent G. Petty, M.D. 600 N. Wolfe Street Baltimore, MD 21287								
31. Date filed (Month, Day, Year) JUL 23 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

2+UA

At the same time, the...

the...

the...

the...

the...

the...

the...

the...

the...

the...

the...

the...

the...

the...

the...

97-4018-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

FRANCIS

State of Maryland / Department of Health and Mental Hygiene

97 22219

BROWN Items: 23a part I, 27, 28a-f per MEO G-749

7/30/97, dh
Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

FRANCES OLIVIA BROWN

2. Date of Death

Month
JULYDay
18Year
1997

3. Time of Death

9:38 P.M.

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-68-1608

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 18, 1963

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street end Number

1522 BRENTWOOD AVENUE

10f. Zip Code

21202

10g. Citizen of What Country?

USA.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 yrs.

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

MAINTENANCE MAN

16b. Kind of Business/Industry

BWI AIRPORT

17. Father's Name (First, Middle, Last)

MANSEL F. BROWN SR.

18. Mother's Name (First, Middle, Maiden Surname)

BEATRICE VAUGHN

19a. Informant's Name/Relationship (Type, Print)

BEATRICE BROWN (MOTHER)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

3149 LYNDAL AVE., BALTIMORE, MD. 21213

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

METRO CREMATORY

Data

7-24-97 BALTIMORE, MARYLAND

20c. Location (City or Town, State)

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME P.A.
2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending Investigation
☐ Accident ☒ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

7/18/97 found

28b. Time of Injury

p 8:55 found

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

subject ingested drugs

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found at home

28f. Location (Street end Number or Rural Route Number, City or Town, State)

1522 Brentwood Avenue, Baltimore, Md.

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 19, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Signature of Registrar

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..
... ..
... ..
... ..

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

22220

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ABE M. COHEN					2. Date of Death JULY 16, 1997 Year		3. Time of Death 3 am	
	4a. Facility Name (If not institution, give street and number) 5021 ARBUTUS AVE.					4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-16-9268		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 28, 1923		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent								
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 5021 ARBUTUS AVE.				10f. Zip Code 21215		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPPLYMAN			16b. Kind of Business/Industry HEALTH DEPARTMENT STATE OF MARYLAND			
17. Father's Name (First, Middle, Last) ISAAC COHEN					18. Mother's Name (First, Middle, Maiden Surname) REBECCA BOBROFSKY				
19a. Informant's Name/Relationship (Type, Print) MRS. ANNA R. COHEN (WIFE)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5021 ARBUTUS AVE. BALTIMORE, MD 21215				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) BNAI ISRAEL -		Date 7-17-1997-	20c. Location - City or Town, State BALTIMORE, MD			
21. Signature of Funeral Service Licensee <i>Sol Levinson</i>					22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 Reisterstown Rd Pikesville, MD 21208				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Diabetes Mellitus Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE									
					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>Dr. Daniel J. Feinstein</i>			29c. License number D28855		29d. Date signed (Month, Day, Year) 7.17.97	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL J. FEINSTEIN 5920 YORK RD BALT, MD 21212									
31. Date filed (Month, Day, Year) 7. JUL 23 1997			32. Registrar's Signature <i>Julia Davidson-Randall</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22221

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Cihlar				2. Date of Death Month Day Year July 22, 1997				3. Time of Death 12:20am	
	4a. Facility Name (If not institution, give street and number) Riverview Nursing Centre				4b. City, Town, or Location of Death Baltimore				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-22-6611		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 25, 1905		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 3 Dunsinane Drive, Apt. L.				10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Henry Lappe'				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Telleland					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joseph W. Cihlar (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Dunsinane Drive, Apt. L., Baltimore, MD 21236					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cem.		Data 7/23/97		20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Schmunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DEMENTIA - PROBABLE ALZHEIMERS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. HYPERTENSION Due to (or as a consequence of): c. STROKE Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION STROKE									
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D40008		29d. Date signed (Month, Day, Year) 7/22/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JIM PARSHALLY, 1105 FRANKLIN SQUARE DR., BALTIMORE, MD									
	31. Date filed (Month, Day, Year) JUL 23 1997									

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

11-197

AM, 320, 700

WRC
97-4016-510
HERMAN
CHAVIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22222

Item: 20b per FH G-749 7/23/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Herman Morgan Chavis

2. Date of Death

Month Day Year
JULY 18, 1997

3. Time of Death

7:12 PM.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-34-7981

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Feb. 27, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

2810 Ulman Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

0

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

—

17. Father's Name (First, Middle, Last)

George Chavis

18. Mother's Name (First, Middle, Maiden Surname)

Ida Mae Chavis

19a. Informant's Name/Relationship (Type, Print) (sister)

Mrs. Delores Rogers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2810 Ulman Ave. Balto. Md. 21215

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

7/23/97

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Arteriosclerotic Cardiovascular Disease

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

INSPECTION

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation
20 Accident 60 Could not be determined
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician

20 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen A. Nach, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22223

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Rose M Cichon</i>				2. Date of Death Month <i>July</i> Day <i>21</i> Year <i>97</i>		3. Time of Death <i>12 35 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>IVY HALL GERIATRIC CENTER</i>				4b. City, Town, or Location of Death <i>MIDDLE RIVER</i>		4c. County of Death <i>BALTIMORE</i>	
Funeral Director	5. Social Security Number <i>216-09-4234</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>77</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>NOV. 21, 1919</i>	9. Birthplace (State or Foreign Country) <i>MARYLAND</i>
	Usual Residence of Decedent				10c. City, Town or Location <i>BALTIMORE CITY</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State <i>MD</i>		10b. County <i>CITY</i>		10e. Street and Number <i>3512 FAIT AVENUE</i>		10f. Zip Code <i>21224</i>		10g. Citizen of What Country? <i>U.S.A.</i>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOUSE WIFE</i>		16b. Kind of Business/Industry <i>DOMESTIC</i>		
17. Father's Name (First, Middle, Last) <i>CHARLES SPERATO</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>MARY DiBERARDO</i>				
19a. Intormant's Name/Relationship (Type, Print) <i>FRANK J. CICHON / HUSBAND</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3512 FAIT AVENUE BALTIMORE, MD 21224</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>ST. STANISLAUS CEMETERY</i>		Date <i>7/24</i>		20c. Location - City or Town, State <i>BALTIMORE, MARYLAND</i>		
21. Signature of Funeral Service Licensee <i>Robert J. Delmonico</i>				22. Name and Address of Facility <i>CHARLES S. ZEILER & SON, INC. 901 SOUTH CONKLING STREET BALTIMORE, MD 21224</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. <i>Possible Sepsis + Aspergillus Fungus</i> 1-2 yrs Due to (or as a consequence of): b. <i>COLD & chr. Renal Failure</i> 2 months + Due to (or as a consequence of): c. <i>End stage lung disease cold</i> 4+ yrs Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D19221</i>		29d. Date signed (Month, Day, Year) <i>7. 22 97</i>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>T. A. Ferozi 223 E. Blvd Balt md 21221</i>								
31. Date filed (Month, Day, Year) <i>JUL 23 1997</i>		32. Registrar's Signature <i>John Davidson-Randall</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

[Faint, illegible handwritten notes or bleed-through from the reverse side of the page.]

97-3901-510

THELMA
CHERRY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22224

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THELMA CHERRY				2. Date of Death Month JULY Day 14 Year 1997		3. Time of Death 6:28 P.M.	
	4e. Facility Name (If not institution, give street and number) 2733 ROUND ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 239-48-3925		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 17, 1930	
	9. Birthplace (State or Foreign Country) NORTH CAROLINA		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2733 ROUND ROAD		10f. Zip Code 21225		10g. Citizen of What Country? USA.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+H GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK		16b. Kind of Business/Industry F.W. WOOLWORTH'S			
	17. Father's Name (First, Middle, Last) WALTER JOSEPH		18. Mother's Name (First, Middle, Maiden Surname) HANNAH HOUSTON		19a. Informant's Name/Relationship (Type, Print) BENJAMIN CHERRY (SON)			
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2512 PARK HEIGHTS TERRACE, BALTO, MD. 21215		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST		20c. Location - City or Town, State 7-21-97 OWINGS MILLS, MD.	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD. 21217					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertension Arteriosclerotic Due to (or as a consequence of): b. Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus				24a. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 15, 1997			
DHM 16 Rev 6/95	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) JUL 23 1997		32. Registrar's Signature 					

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22225

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carrie E. Deans

2. Date of Death

Month
July

Day

18,

Year

1997

3. Time of Death

7:22 pm

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

212-22-1015

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

06-18-21

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

601 E. 29th Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (14 or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Receptionist

16b. Kind of Business/Industry

People's Comm.
Health Ctn.

17. Father's Name (First, Middle, Last)

Wilbert

Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Ethel

Johnson

19a. Informant's Name/Relationship (Type, Print)

Roberta Taylor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2956 Greenmount Avenue Baltimore, Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore Cemetery 02-24-97 Baltimore, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Lucy M. Smith

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory failure

Due to (or as a consequence of):

2 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pulmonary embolus

Due to (or as a consequence of):

4 hours

c. Hypercoagulable state

Due to (or as a consequence of):

14 days

d. Repair of abdominal aortic aneurysm

15 days

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kathryn M. Walcott, M.D.

29c. License number

AU 4176435W8610

29d. Date signed (Month, Day, Year)

July 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kathryn M. Walcott, M.D., 201 E. University Pkwy., Dept. of Medicine, Baltimore, MD 21218

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

T

10-10-10

10-10-10

10-10-10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22226

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Mae DAUGHERTY

2. Date of Death

Month Day Year
July 15, 1997

3. Time of Death

7:20 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

219 14 9195

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 19, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6087 Marquette Road

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Alexander Jacobs

18. Mother's Name (First, Middle, Maiden Surname)

Julia (unknown)

19a. Informant's Name/Relationship (Type, Print)

Julia Weber / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 W. Jeffrey Street Baltimore, Maryland 21225

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

7/17/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Small Cell Carcinoma

Due to (or as a consequence of):

b. Acute Renal Failure

Due to (or as a consequence of):

c. Liver Metastases

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Non insulin dependent diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

RD2327

29d. Date signed (Month, Day, Year)

7/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pedro Amador, MD 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

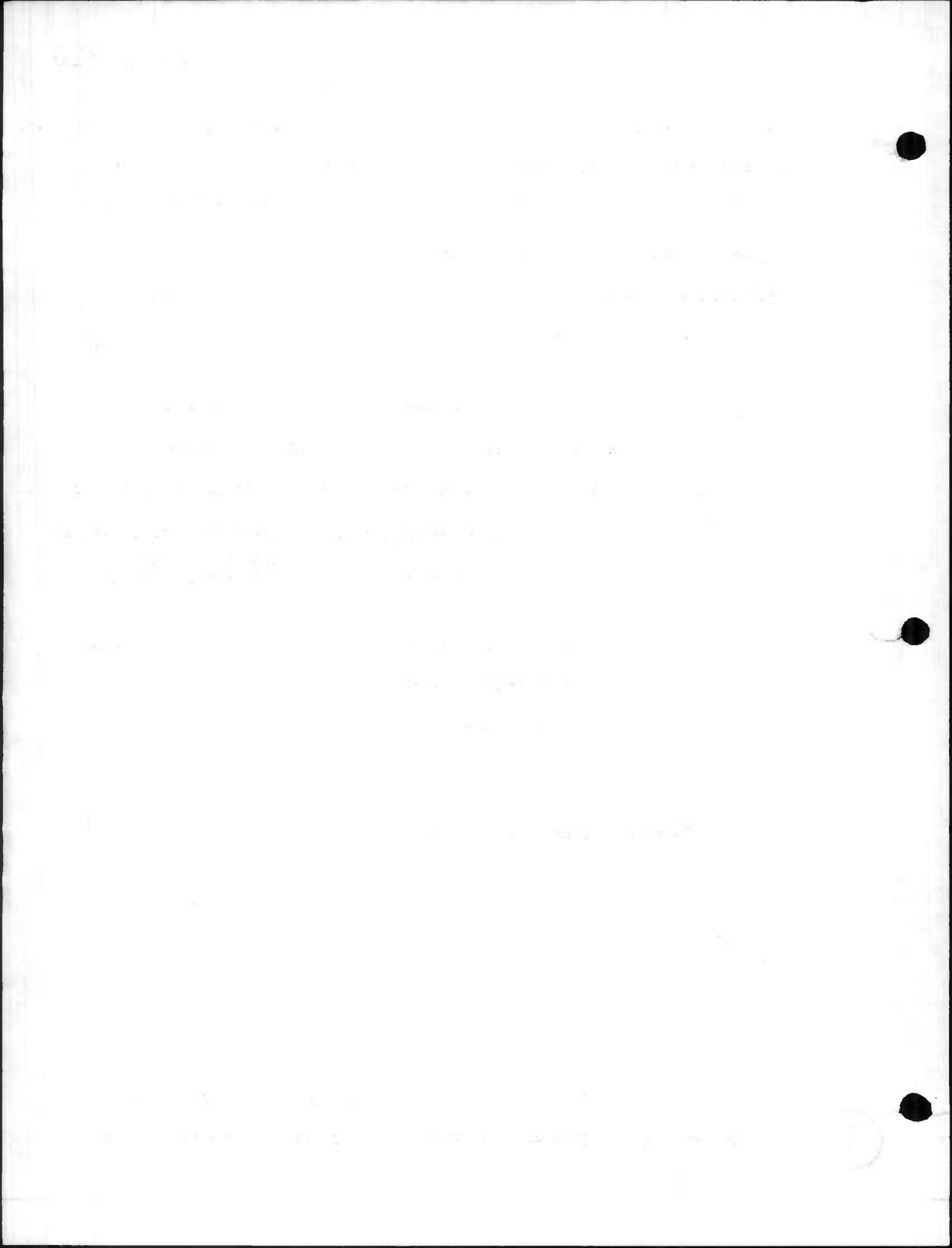
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97-4049-510

B.K.S

ERROL ANTHONY DOWNER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22227

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERROL ANTHONY DOWNER

2. Date of Death

Month Day Year
JULY 20, 1997

3. Time of Death

1047 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL E.R.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

113-82-5069

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 3, 1964

9. Birthplace (State or Foreign Country)

JAMAICA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE COUNTY

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

402 SHADE TREE PLACE

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STORE OWNER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

JOYCE HEMMINGS

19a. Informant's Name/Relationship (Type, Print)

MAUDE HARRIS/GODMOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4408 PEN LUCY ROAD, BALTIMORE, MARYLAND 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK

Date

7-24-97

20c. Location - City or Town, State

WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVENUE, BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Stephen S. Radentz, MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10. 1. 1950

10. 1. 1950

10. 1. 1950

10. 1. 1950

10. 1. 1950

10. 1. 1950

10. 1. 1950

10. 1. 1950

10. 1. 1950

10. 1. 1950

10. 1. 1950

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22228

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERNICE AMERNICK EDLOW			2. Date of Death Month JULY Day 18 Year 1997		3. Time of Death 10:51 AM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-20-5949		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 11, 1926
	9. Birthplace (State or Foreign Country) MARYLAND						
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 3041 FALLSTAFF RD., APT. 106			10f. Zip Code 21209		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOUNDER		16b. Kind of Business/Industry YOGURT TREE		
	17. Father's Name (First, Middle, Last) ISADORE AMERNICK			18. Mother's Name (First, Middle, Maiden Surname) DOROTHY PRESSMAN			
	19a. Informant's Name/Relationship (Type, Print) THEODORE M. EDLOW (HUS.)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3041 FALLSTAFF RD., APT. 106 BALTO., MD 21209			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH EL MEMORIAL PARK		Date 7/20/1997	20c. Location - City or Town, State RANDALLSTOWN, MD	
	21. Signature of Funeral Service Licensee <i>Jay Alan Lewis</i>			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOPULMONARY ARREST Due to (or as a consequence of): ATHEROSCLEROTIC CORONARY DISEASE HYPERTENSION						
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stage IV Cancer of Cervix						
Physician /Medical Examiner	23a. Immediate Cause (Final disease or condition resulting in death) CARDIOPULMONARY ARREST		23b. Due to (or as a consequence of): ATHEROSCLEROTIC CORONARY DISEASE		23c. Due to (or as a consequence of): HYPERTENSION		
	23d. Due to (or as a consequence of):		23e. Due to (or as a consequence of):		23f. Due to (or as a consequence of):		
	23g. Due to (or as a consequence of):		23h. Due to (or as a consequence of):		23i. Due to (or as a consequence of):		
	23j. Due to (or as a consequence of):		23k. Due to (or as a consequence of):		23l. Due to (or as a consequence of):		
	23m. Due to (or as a consequence of):		23n. Due to (or as a consequence of):		23o. Due to (or as a consequence of):		
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
	29b. Signature and title of certifier <i>Lawrence Scharf</i>		29c. License number 043173		29d. Date signed (Month, Day, Year) 7-18-97		
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LAWRENCE SCHARF, M.D. 7605 OSLER DRIVE TOWSON, MARYLAND 21204						
	31. Date filed (Month, Day, Year) JUL 23 1997		32. Registrar's Signature <i>Julia Davidson-Randall</i>				

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

6

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22229

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mollie

Eisenberg

2. Date of Death

Month Day Year
JULY 19, 1997

3. Time of Death

1:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216-30-7283

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 31, 1900

9. Birthplace (State or Foreign Country)

Romania

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

300 International Circle

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☐ Married
☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Benjamin

Eisenberg

18. Mother's Name (First, Middle, Maiden Surname)

Yetta

Siegel

19a. Informant's Name/Relationship (Type, Print)

Mrs. Bernice Schlenger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23 Stonehenge Circle Apt 8, Baltimore, MD 21208

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington (Chizuk Amuno)

Date

7/20/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Scott M. Guttler

22. Name and Address of Facility

Sol Levinson & Bros.
8900 Reisterstown Rd, Pikesville, MD 2120823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Dua to (or as a consequence of):

Acute MI

b.

Dua to (or as a consequence of):

Probable Acute Pancreatitis

c.

Dua to (or as a consequence of):

Anemia

d.

COPD

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Anne F. Wills MD

29c. License number

D51407

29d. Date signed (Month, Day, Year)

July 19, 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Anne F. Wills MD 1407 York RD Suite 309 Lutherville MD 21093

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22230

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clara Minerva Ehman

2. Date of Death

Month Day Year
July 20, 1997

3. Time of Death

11:25 a.m.

4a. Facility Name (If not institution, give street and number)

Dulaney Valley Assisted Care

4b. City, Town, or Location of Death

Phoenix

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-36-8785

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 3, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

57 Belfast Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

William Snyder

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth

Unknown

19a. Informant's Name/Relationship (Type, Print)

Mr. Edward R. Ehman/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

57 Belfast Road Timonium, Maryland 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corp.

Date

7/24/97

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.)

Immediate Cause (Final disease or condition resulting in death)

e. Hypertension

Due to (or as a consequence of):

Approximate interval Between Onset and Death

25y

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NIDDM, hypothyroidism, dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jeffrey L. Gair

29c. License number

D41104

29d. Date signed (Month, Day, Year)

7.21.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ted Houck MD 7825 York Rd Towson MD 21204

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

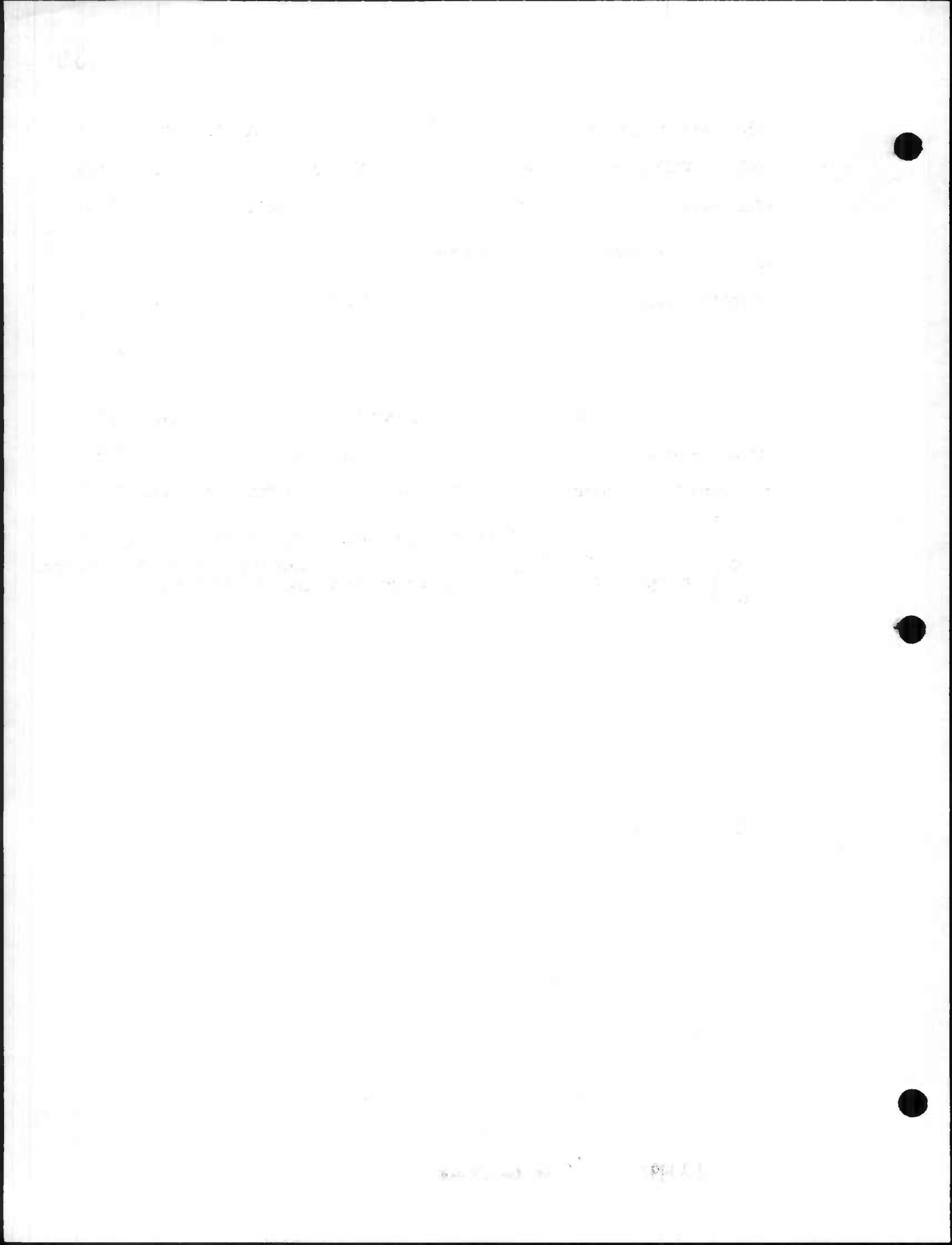
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22231**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILTON EDELSON				2. Date of Death Month JULY Day 16 Year 1997		3. Time of Death 5:26AM		
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 213-18-3385		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC.16,1918	9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 3022-C NORTHBROOK RD.				10f. Zip Code 21209		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSURANCE AGENT			16b. Kind of Business/Industry UNITED INSURANCE		
17. Father's Name (First, Middle, Last) LOUIS EDELSON				18. Mother's Name (First, Middle, Maiden Summa) ANNA UNKNOWN					
19a. Informant's Name/Relationship (Type, Print) PAULINE EDELSON (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3022-C NORTHBROOK RD. BALTO., MD 21209					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON (CHIZUK AMUNO)		Date 7/17/97		20c. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee <i>Jay Alan Lewis</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. END STAGE RENAL FAILURE Due to (or as a consequence of): c. AORTIC STENOSIS Due to (or as a consequence of): d. MYOCARDIAL ISCHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION DIABETES MELLITUS ATRIAL FIBRILLATION									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <i>J. Bowers</i>				29c. License number AS-2402321-JB9338		29d. Date signed (Month, Day, Year) JULY 16, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMELLE BOWERS, MD 2401 WEST BELVEDERE AVENUE BALTIMORE, MARYLAND 21215									
31. Date filed (Month, Day, Year) JUL 23 1997				32. Registrar's Signature <i>Shirley Davidson-Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a summary of the work done.

6. The sixth part is a list of the names of the people who helped.

7. The seventh part is a list of the names of the people who helped.

8. The eighth part is a list of the names of the people who helped.

9. The ninth part is a list of the names of the people who helped.

10. The tenth part is a list of the names of the people who helped.

11. The eleventh part is a list of the names of the people who helped.

12. The twelfth part is a list of the names of the people who helped.

13. The thirteenth part is a list of the names of the people who helped.

14. The fourteenth part is a list of the names of the people who helped.

15. The fifteenth part is a list of the names of the people who helped.

16. The sixteenth part is a list of the names of the people who helped.

17. The seventeenth part is a list of the names of the people who helped.

18. The eighteenth part is a list of the names of the people who helped.

19. The nineteenth part is a list of the names of the people who helped.

20. The twentieth part is a list of the names of the people who helped.

21. The twenty-first part is a list of the names of the people who helped.

22. The twenty-second part is a list of the names of the people who helped.

23. The twenty-third part is a list of the names of the people who helped.

24. The twenty-fourth part is a list of the names of the people who helped.

25. The twenty-fifth part is a list of the names of the people who helped.

26. The twenty-sixth part is a list of the names of the people who helped.

27. The twenty-seventh part is a list of the names of the people who helped.

28. The twenty-eighth part is a list of the names of the people who helped.

29. The twenty-ninth part is a list of the names of the people who helped.

30. The thirtieth part is a list of the names of the people who helped.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22232

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Deborah Gaither

2. Date of Death

Month Day Year 11 PM
July 12 1997

3. Time of Death

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

2533 Loyola Southway

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-54-4876

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Oct. 3, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2533 Loyola Southway

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Bethlehem Steel Co.

17. Father's Name (First, Middle, Last)

Melvin Gaither

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Snowden

19a. Informant's Name/Relationship (Type, Print)

Mr. Damon Gaither (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

45940 Indian Way Lexington Park, Md. 20653

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion

Date

7/22/97

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Atrial Fibrillation

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

years

b.

Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

year

c.

Hypertension

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)Residing
Home

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Amatur H. Harem M.D.

29c. License number

D15503

29d. Date signed (Month, Day, Year)

JULY 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501 Dolphin Street Baltimore, MD 21217

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia H. Harem

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

21 55535

JUL 8 3 1957

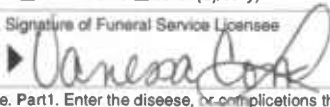
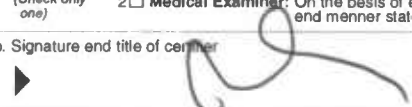
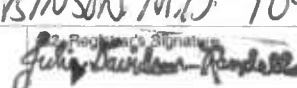
T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22233

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James B. Griffin				2. Date of Death Month July Day 16 Year 97		3. Time of Death 3:30pm				
	4a. Facility Name (If not institution, give street and number) 837 East Chase Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA				
Funeral Director	5. Social Security Number 220-36-6458		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) 07-10-40				
	9. Birthplace (State or Foreign Country) Md.		10a. State Md		10b. County NA		10c. City, Town or Location Baltimore				
Usual Residence of Decedent											
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number 837 East Chase Street			10f. Zip Code 21202		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietary Cook			16b. Kind of Business/Industry Correction State of Md.-					
17. Father's Name (First, Middle, Last) James H. Griffin					18. Mother's Name (First, Middle, Maiden Surname) Alice Spivey						
19a. Informant's Name/Relationship (Type, Print) Ophelia Griffin					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 837 E. Chase Street Baltimore, Maryland 21202						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem. Pk. Cem. 07-23-97 Randallstown, Md.			20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Gastric Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. { c. { d. {									Approximate Interval Between Onset and Death 3 years		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Left Renal Carcinoma Hypertension									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number D 31811		29d. Date signed (Month, Day, Year) 7-22-97			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RAMONA L. ROBINSON M.D. 709 E. COMSAL ST BALD, MD. 21202											
31. Date filed (Month, Day, Year) JUL 23 1997									32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

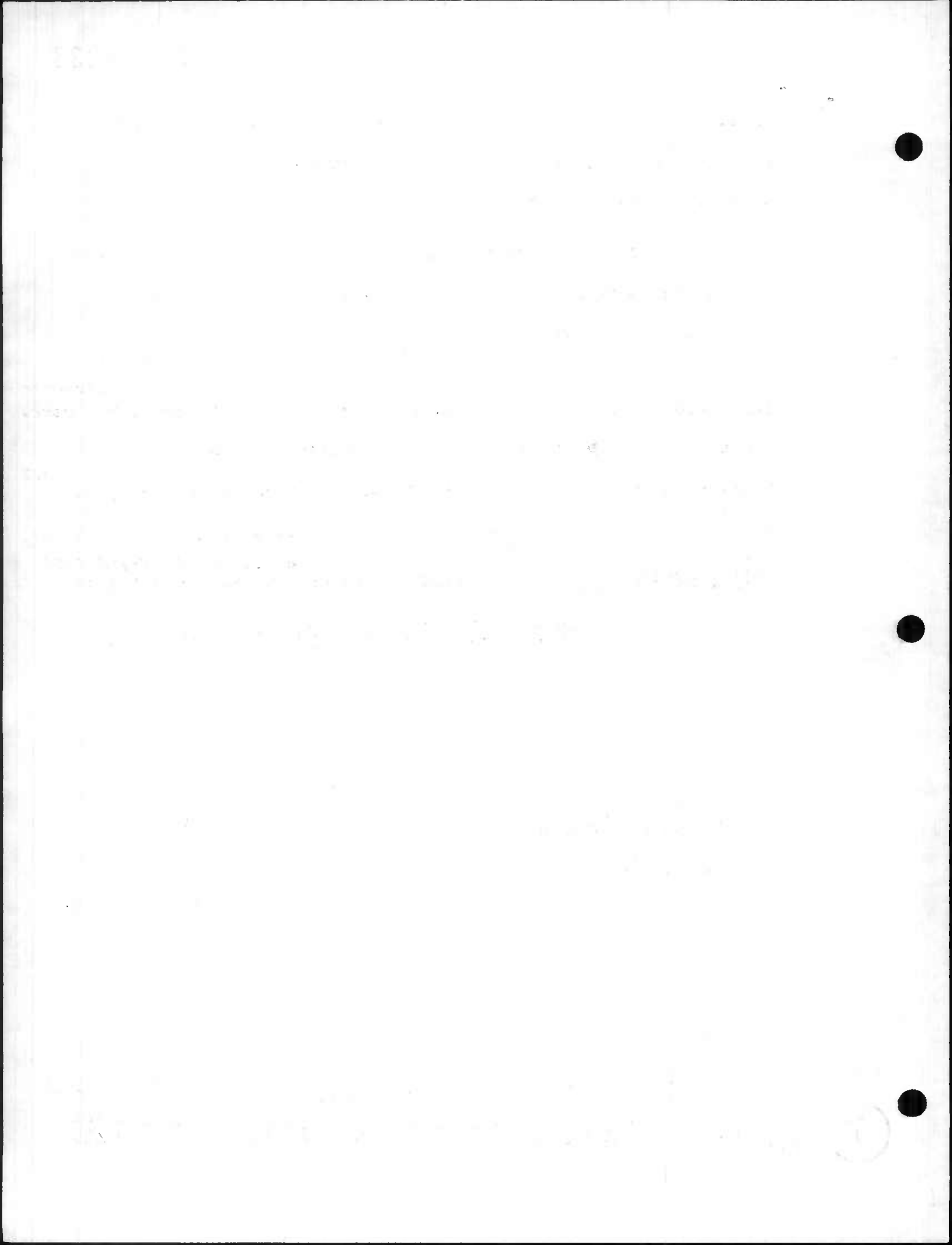
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



WRC
97-4006-510
LINDA

HARRIGAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22234

Items 23a part I, 27, 28a-f per MEO G-752 11/15/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Linda Dawn Harrigan

2. Date of Death
Month Day Year
JULY 17, 1997

3. Time of Death
5:35 PM.

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number
219-56-5721

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
47 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
Sept. 15, 1949

9. Birthplace (State or Foreign
Country)
Maryland

Usual Residence of Decedent

10e. State
Maryland

10b. County
Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9525 Horn Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.
Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
11th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Edgar N. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Celesta Poe

19e. Informant's Name/Relationship (Type, Print)

Patrick Harrigan (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9525 Horn Avenue, Baltimore, MD 21236

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Cemetery

Date

7/21/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.

9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

PULMONARY THROMBO-EMBOLISM COMPLICATING LACERATION OF RIGHT URETER

Approximate
Interval Between
Onset and Death

Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy
performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury
(Month, Day, Year)
6/25/97

28b. Time of
Injury
11:00 A
to 5:00 P M

28c. Injury at
Work?
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

laceration of ureter

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)
hospital

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 201 East University
Pkwy., Baltimore, Maryland

29a. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

J. Harrison-Randall

State
Registrar

Baltimore, Maryland 21215-0020

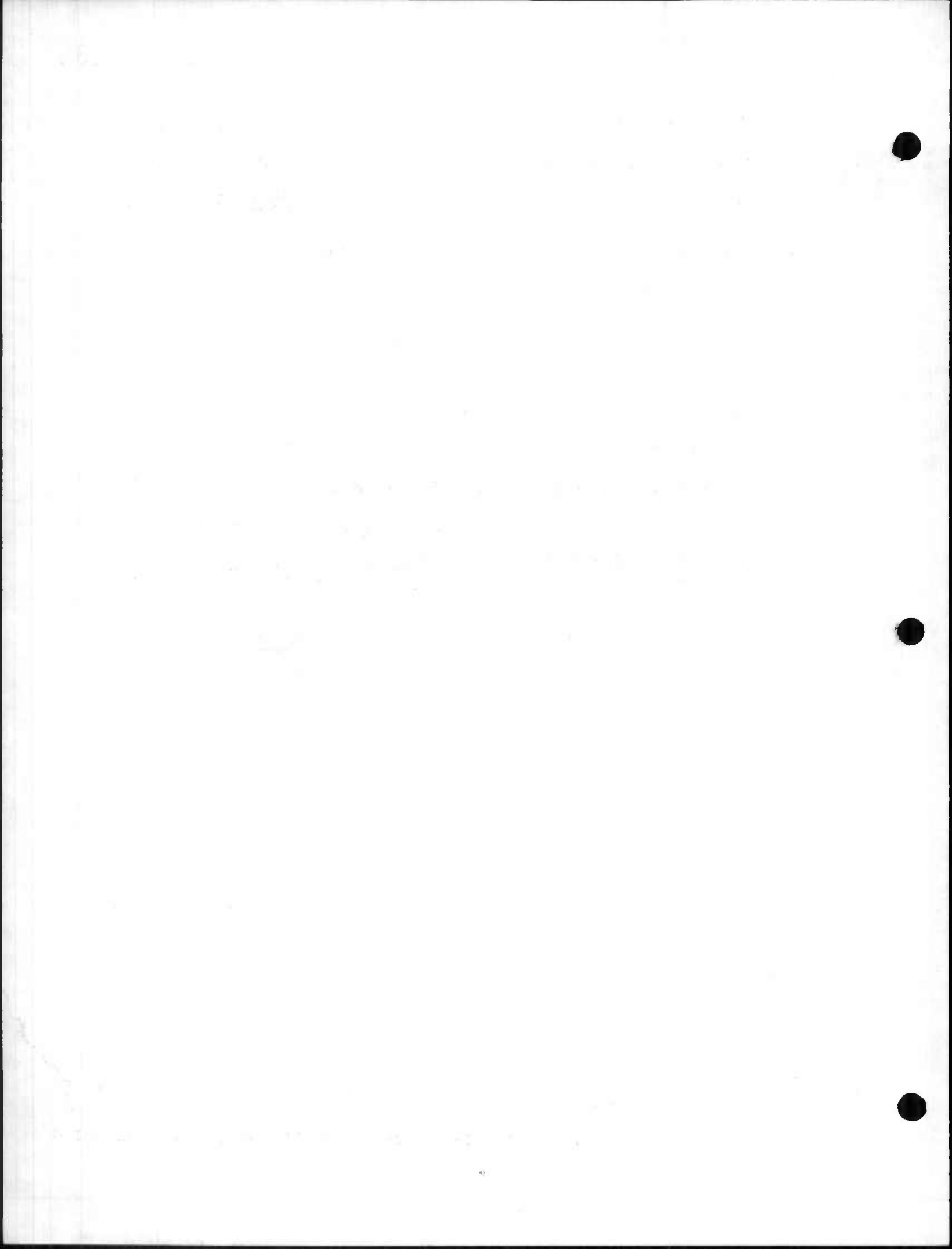
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22235

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anita M. Hunter				2. Date of Death Month Day Year July 18, 1997		3. Time of Death 8:48 AM	
	4a. Facility Name (If not institution, give street and number) 3324 Essex Road				4b. City, Town, or Location of Death Woodmoor		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-30-8832		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 8, 1932	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Woodmoor		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3324 Essex Road				10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Customer Service Representative		16b. Kind of Business/Industry Blazer Finance		
17. Father's Name (First, Middle, Last) John F. Bell				18. Mother's Name (First, Middle, Maiden Surname) Martha V. Reeder				
19a. Informant's Name/Relationship (Type, Print) Mr. John E. Hunter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3324 Essex Road Baltimore, MD 21207				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Cem.		Date 7/21/97		20c. Location - City or Town, State Ellicott City, MD		
21. Signature of Funeral Service Licensee Joseph J. Kellner				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133-4784				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BREAST CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 YR								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number D35606		29d. Date signed (Month, Day, Year) 7/18/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Zyglar MD 21 Crossroads Drive #415 Owings Mills MD 21117								
31. Date filed (Month, Day, Year) JUL 23 1997				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMH 16 Rev 6/95

612

24

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200.

201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300.

301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400.

401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500.

501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600.

601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700.

701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800.

801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900.

901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000.

1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

22236

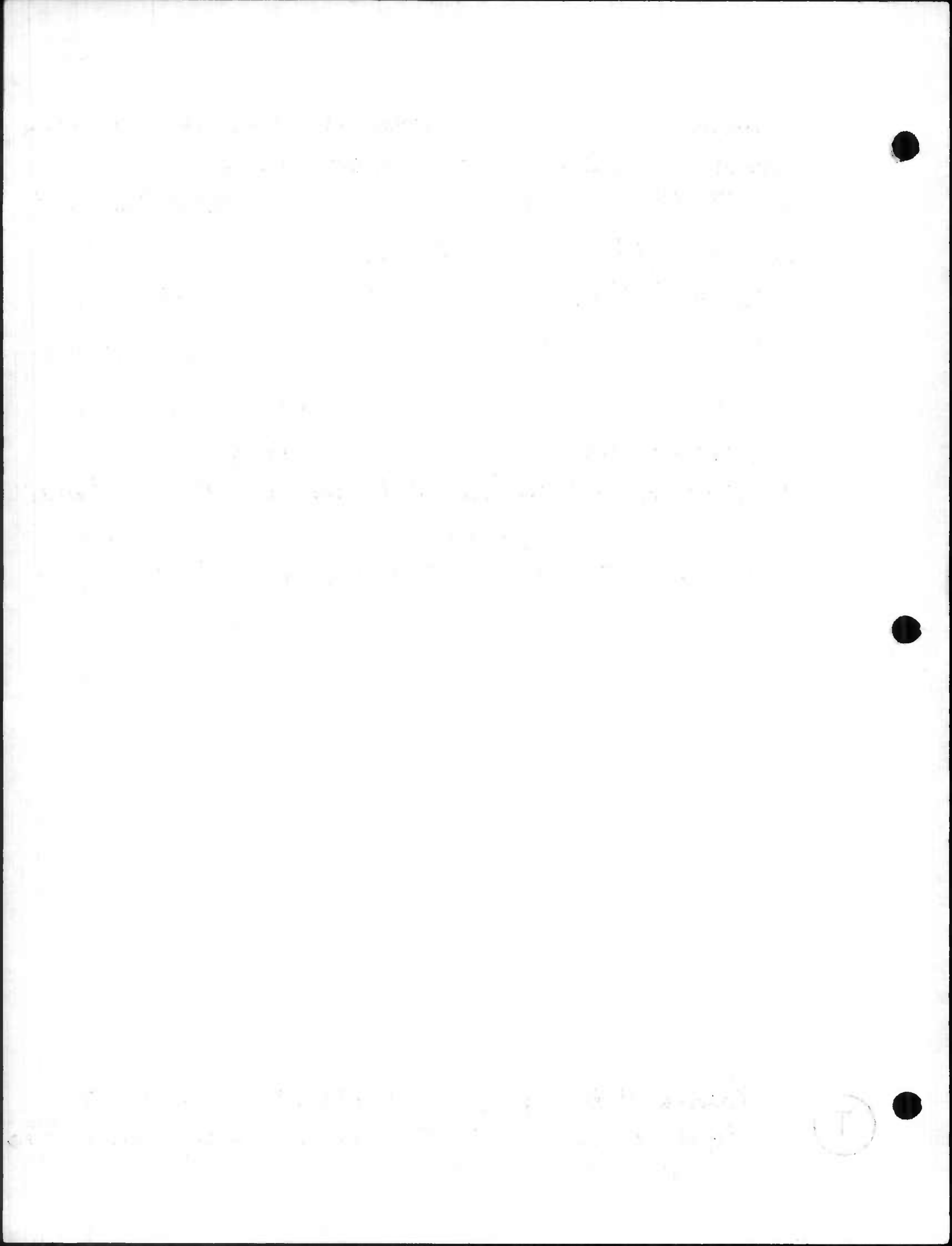
Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|---|--------------------------------|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LYNETTE | | | | 2. Date of Death
Month JULY Day 18 Year 1997 | | | | 3. Time of Death
2:10 AM | |
| | 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS BAYVIEW MED CENTER BALTIMORE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
— | |
| Funeral
Director | 5. Social Security Number
215-78-0805 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
40 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
AUG 6, 1956 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
923 N. Fulton Ave. | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Afro-American | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Linwood Holloway | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Shirley Jones | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Ms. Pamela Nelson (sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
923 N. Fulton Ave. Balto. Md. 21217 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial | | 20c. Date
7/24/97 | | 20d. Location - City or Town, State
Balto. Md. | | | |
| | 21. Signature of Funeral Service Licensee
Joseph L. Russ | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216 | | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. STAPHYLOCOCCAL ENDOCARDITIS
Due to (or as a consequence of):
b. STAPHYLOCOCCAL PNEUMONIA
Due to (or as a consequence of):
c. HUMAN IMMUNODEFICIENCY VIRUS INFECTION
Due to (or as a consequence of):
(END STAGE AIDS) | | | | | | | | Approximate Interval Between Onset and Death
2 WKS
3 WKS
UNKNOWN | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HIV DEMENTIA
SCHIZOPHRENIA
NEUROSYPHILIS | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State
Registrar | 29b. Signature and title of certifier
Patrick A. Murphy | | | | 29c. License number
D 13688 | | 29d. Date signed (Month, Day, Year)
07/18/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PATRICK A MURPHY, 8 SCOTTSDALE COURT, WATERSVILLE MD 21093 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | | | | | | | | |
| 32. Registrar's Signature
John Davidson-Randall | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22237

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELOUISE HAMILTON

2. Date of Death

Month July Day 19 Year 1997

3. Time of Death

6:30 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

212-18-2453

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Dec. 15, 1915 South Carolina

Usual Residence of Decedent

Maryland

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3508 Jean Drive

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Negro

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic Engineer

16b. Kind of Business/Industry

Outside Home

17. Father's Name (First, Middle, Last)

Ike Gladney

18. Mother's Name (First, Middle, Maiden Surname)

Ella Saunders

19a. Informant's Name/Relationship (Type, Print)

Mrs. Dollie Gladney (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

309 Denison St. Balto, Md. 21229

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus

Date

7/25/97

20c. Location - City or Town, State

Balto, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute cerebro-vascular accident

Approximate Interval Between Onset and Death

20 Yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INSULIN DEPENDENT DIABETES MELLITUS

HEMORRHAGIC CYSTITIS

DEMENCIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Julia Davidson-Randall MD

29c. License number

D19502

29d. Date signed (Month, Day, Year)

July 19, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ORLANDO B. CONNAN MD

NORTHWEST HOSPITAL CENTER
RANDALLSTOWN Md. 21133

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22238

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--------------------------------|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLES HAMMOND | | | | 2. Date of Death
Month JULY Day 18 Year 1997 | | 3. Time of Death
5:30 PM | |
| | 4a. Facility Name (If not institution, give street and number)
2548 W. BALTIMORE STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-24-5696 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
NOV. 26, 1907 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | 10a. State
MARYLAND | | | | | | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
BALTIMORE CITY | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
2548 W. BALTIMORE STREET | | | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
USA. | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) UNKNOWN | | College (1-4 or 5+) UNKNOWN | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
ROYAL THEATER | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
EDWARD HAMMOND | | | | 18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
NANCY JONES (Cousin) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2548 W. BALTIMORE ST. BALTIMORE, MD. 21223 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WESTERN STAR CEME. 7-2297 CATONSVILLE, MD. | | 20c. Location - City or Town, State | | 20d. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVENUE, BALTIMORE, MD. 21217 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of the Liver
Due to (or as a consequence of):
b. Dehydration
Due to (or as a consequence of):
c. active advanced Paget's disease
Due to (or as a consequence of):
d. Atherosclerotic disease | | | | | | | Approximate Interval Between Onset and Death
1 mo
2 wks
10 yrs
10 yrs |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | 29b. Signature and title of certifier
 |
| | 29c. License number
D29769 | | | | | | | 29d. Date signed (Month, Day, Year)
7/21/97 |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
marcelino D. Albuerne 516 W. Rolling Rd Balt. | | | | | | | 31. Data filed (Month, Day, Year)
JUL 23 1997 |
| | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the research and the objectives of the study.

2. The second part of the report is a detailed description of the methodology used in the study. It includes information about the sample size, the data collection methods, and the statistical analysis techniques.

3. The third part of the report is a discussion of the results of the study. It presents the findings of the research and discusses their implications for the field of study.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22239

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Willie Hoyle

2. Date of Death

Month

Day

Year

3. Time of Death

1:10 AM

4a. Facility Name (If not institution, give street and number)

DEATON UMMS

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

238-32-7672

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAY 22, 1924

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1834 N. BROADWAY

10f. Zip Code

21213

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 + H GRADE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ELEVATOR OPERATOR

16b. Kind of Business/Industry

BALTIMORE SUNPAPER

17. Father's Name (First, Middle, Last)

FRANK

HOYLE

18. Mother's Name (First, Middle, Maiden Surname)

CLARA

LEPPER

19a. Informant's Name/Relationship (Type, Print)

MARGARET H. CRAWFORD (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1107 GREEN CIRCLE DR., GASTONIA, NC 28054

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING PARK CEMETERY

Date

7-24-97

20c. Location - City or Town, State

WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Diabetes mellitus B

b.

Due to (or as a consequence of):

sepsis

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Yrs

Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 28992

29d. Date signed (Month, Day, Year)

July 19, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRITAM SAWHNEY
9101 Cherry Ln # 211 Laurel MD 20708

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1871
1872
1873

1874
1875
1876

1877
1878
1879
1880
1881
1882
1883
1884
1885
1886
1887
1888
1889
1890
1891
1892
1893
1894
1895
1896
1897
1898
1899
1900

1901
1902
1903
1904
1905
1906
1907
1908
1909
1910
1911
1912
1913
1914
1915
1916
1917
1918
1919
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22240

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|---|-------------------------|---|---|-------------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Oakland Johnson, Jr. | | | | 2. Date of Death
Month Day Year
July 18 97 | | 3. Time of Death
3:00pm | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number)
1134 E. Belvedere Avenue Apt "D" | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | | | | | | |
| Funeral
Director | 5. Social Security Number
219-28-8180 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
63 Yrs. | | 8. Date of Birth (Month, Day, Year)
10-31-33 | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Md. | | 10. Usual Residence of Decedent | | 11. Under 1 Year
Months Days | | 12. Under 24 Hrs.
Hours Min. | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| | 10e. Street and Number
1134 E. Belvedere Ave Apt. "D" | | | | 10f. Zip Code
21239 | | 10g. Citizen of What Country?
USA | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates:
Army | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
11th Grade NA | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | 16b. Kind of Business/Industry
Laundry Factory | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Oakland Johnson, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Epps | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Vickie Caple | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1115 Ramblewood Road Apt. "A" Baltimore, Md. 21239 | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest VA Cem. 07-24-97 Owings Mills, | | 20c. Location - City or Town, State
Md. | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Delmar Davis</i> | | | | 22. Name and Address of Facility
Baltimore, Maryland
WM.C. March FH 1101 E. North Avenue | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Sudden Cardiac Death</td> <td rowspan="4">Approximate Interval Between Onset and Death
acute</td> </tr> <tr> <td>b. Hypertensive Atherosclerotic Heart Disease</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Sudden Cardiac Death | Approximate Interval Between Onset and Death
acute | b. Hypertensive Atherosclerotic Heart Disease | c. Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) | a. Sudden Cardiac Death | Approximate Interval Between Onset and Death
acute | | | | | | | | | | | |
| | b. Hypertensive Atherosclerotic Heart Disease | | | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dr. Duncan Salmon</i> | | 29c. License number
25733 | | 29d. Date signed (Month, Day, Year)
07/21/97 | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DUNCAN SALMON 5601 Loch Raven Blvd Baltimore MD 21239 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

541

DHMH 16 Rev 6/95

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

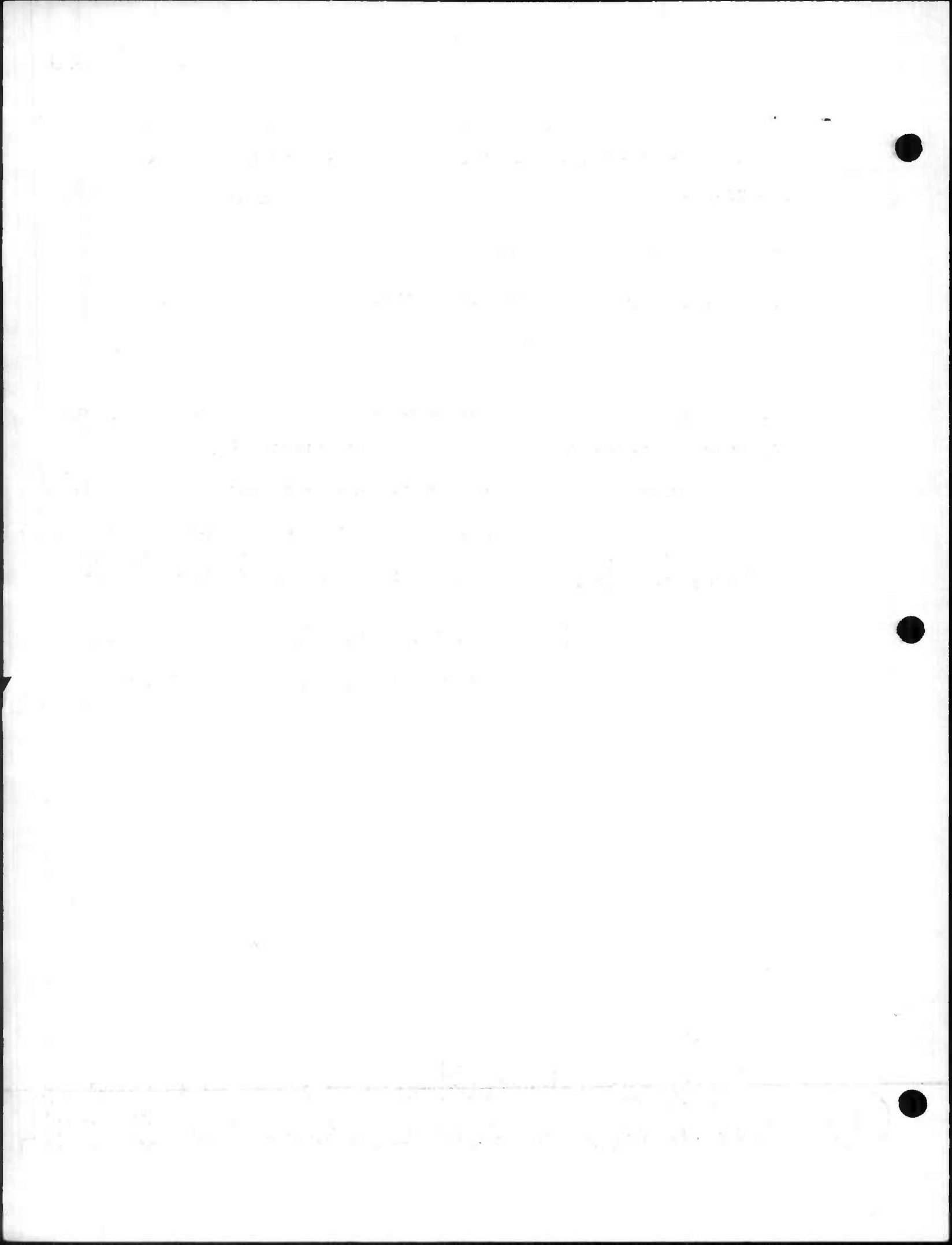
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

T

State
Registrar

87VA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22241

| | | | | | | | |
|--|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ETHEL MARIE JOHNSON | | | 2. Date of Death
Month Day Year
JULY 16 1997 | | 3. Time of Death
9:48 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
GENESIS NURSING HOME | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
218-10-6295 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
95 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
SEPT. 24, 1901 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
BALTIMORE | 10c. City, Town or Location
RANDALLSTOWN | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
9109 LIBERTY ROAD | | | 10f. Zip Code
21133 | | 10g. Citizen of What Country?
USA. | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12+H GRADE
College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BEAUTICIAN | | 16b. Kind of Business/Industry
BEAUTY SALON | | |
| | 17. Father's Name (First, Middle, Last)
PAIGE JOHNSON | | | 18. Mother's Name (First, Middle, Maiden Surname)
ALLOINA PARKER | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
REBECCA HALL (NEICE) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5715 PARK HEIGHTS AVE., BALTIMORE, MD. 21215 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEW CATHEDRAL | | 20c. Location - City or Town, State
7-2397 BALTIMORE, MARYLAND | | |
| | 21. Signature of Funeral Service Licenses
 | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTIMORE MD. 21217 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CEREBRO VASCULAR ACCIDENT
Due to (or as a consequence of):
b. GENERALIZED ARTERIOSCLEROSIS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- TUBE FEEDER
DEMENTIA | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| State Registrar | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
D-22609. | | 29d. Date signed (Month, Day, Year)
JULY 17-1997. | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
RUBEN REIDER M.D. 7445 FURNACE BRANCH RD GLEN BURNIE MD 21060 | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997
 | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22242

| | | | | | | | | |
|--|--|--|---|--|--|--------------------------------|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Percy King | | | | 2. Date of Death
Month July Day 21 Year 1997 | | 3. Time of Death
12:19A | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
217-24-1966 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
DEC. 17, 1929 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
476 CUMMING COURT | | | | 10f. Zip Code
21201 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
6TH GRADE | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
HOUSING AUTHORITY | | | |
| Physician
/Medical
Examiner | 17. Father's Name (First, Middle, Last)
JOSEPH HOLMES | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARGARET KING | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
DEBORAH YOUNG (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7522 SHELWOOD RD., BALTIMORE, MD. 21208 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING MEMORIAL PARK | | 20c. Location - City or Town, State
7-25-97 WOODLAWN, MD. | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE., BALTIMORE, MD. 21217 | | | | | |
| Physician
/Medical
Examiner | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. respiratory distress Due to (or as a consequence of): 13 days
b. pneumonia Due to (or as a consequence of): 13 days
c. self-starvation Due to (or as a consequence of): 5 weeks
d.

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Seizure disorder
cerebrovascular accident Secondary to hypertension
bipolar disorder | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | | | 29c. License number
AS2402321DP9287 | | 29d. Date signed (Month, Day, Year)
July 21, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Danielle D. Pritchett, M.D. Sinai Hospital of Baltimore | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | | | | | | |

At the time of the ...

... ..

... ..

...

... ..

... ..

... ..

... ..

... ..

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22243

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|-------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
IDA BOLANDER KRAMER | | | | 2. Date of Death
Month Day Year
July 21, 1997 | | 3. Time of Death
4:45 PM | |
| | 4a. Facility Name (If not institution, give street and number)
26 Dunvale Rd. Apt. "D" | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
213-28-3846 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
68 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 20, 1928 | |
| | 10e. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
26 Dunvale Rd. Apt. "D" | | | | 10f. Zip Code
21204 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Book Keeper | | 16b. Kind of Business/Industry
Accounting | | | |
| | 17. Father's Name (First, Middle, Last)
William Bolander | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ida V. Taylor | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mr. Robert L. Kramer/husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26 Dunvale Rd. Apt. "D" Towson, Md. 21204 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial | | Date
7/25/97 | | 20c. Location - City or Town, State
Timonium, Md. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Bladder Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| | Approximate Interval Between Onset and Death
4 months | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Paul Celano, M.D. | | | | 29c. License number
D30929 | | 29d. Date signed (Month, Day, Year)
7/22/97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
PAUL CELANO, MD 6569 N. Charles ST, BALTIMORE, MD 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | 32. Registrar's Signature
John Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Richard Vickers Kendall | | | | 2. DATE OF DEATH
JULY 21, 1997 | | 3. TIME OF DEATH
3:00 A M | |
| 4. SOCIAL SECURITY NUMBER
218-14-9346 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Aug. 7 1917 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
204 E. Joppa Rd. #715 | | 9b. CITY, TOWN OR LOCATION OF DEATH
Towson | |
| 9c. COUNTY OF DEATH
Baltimore | | | | 10a. STATE
MD. | | 10b. COUNTY
Baltimore | |
| 10c. CITY, TOWN OR LOCATION
Towson | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
204 E. Joppa Rd. #715 | |
| 10f. ZIP CODE
21286 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (8-12) College (1-4 or 5+) +7 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Lawyer | | 16b. KIND OF BUSINESS/INDUSTRY
Government | |
| 17. FATHER'S NAME (First, Middle, Last)
William Kendall | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ida Roberta Naser | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Anne Vickers Lukaszuk/Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9802 Wilbert Ave. Baltimore, MD. 21234 | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Hilltop Service Co. 7-23-97 | | 20c. LOCATION — City or Town, State
Towson, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204 | | | |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. 22 Calibre Bullet to Rt Temple
DUE TO (OR AS A CONSEQUENCE OF):
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year)
July 21, 1997 | | 28b. TIME OF INJURY
3:00 A M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED
3201 Pisto / Wound to Rt Temple | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)
RT Home | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
204 E. Joppa Rd. Towson, MD. 21286 | | | |
| 29. CERTIFIER
(Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D-09383 | | 29d. DATE SIGNED (Month, Day, Year)
July 21, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles F O'Donnell MD - 11146 Maple Hill Rd Baltimore Maryland 21210 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JUL 23 1997 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 6876
 BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

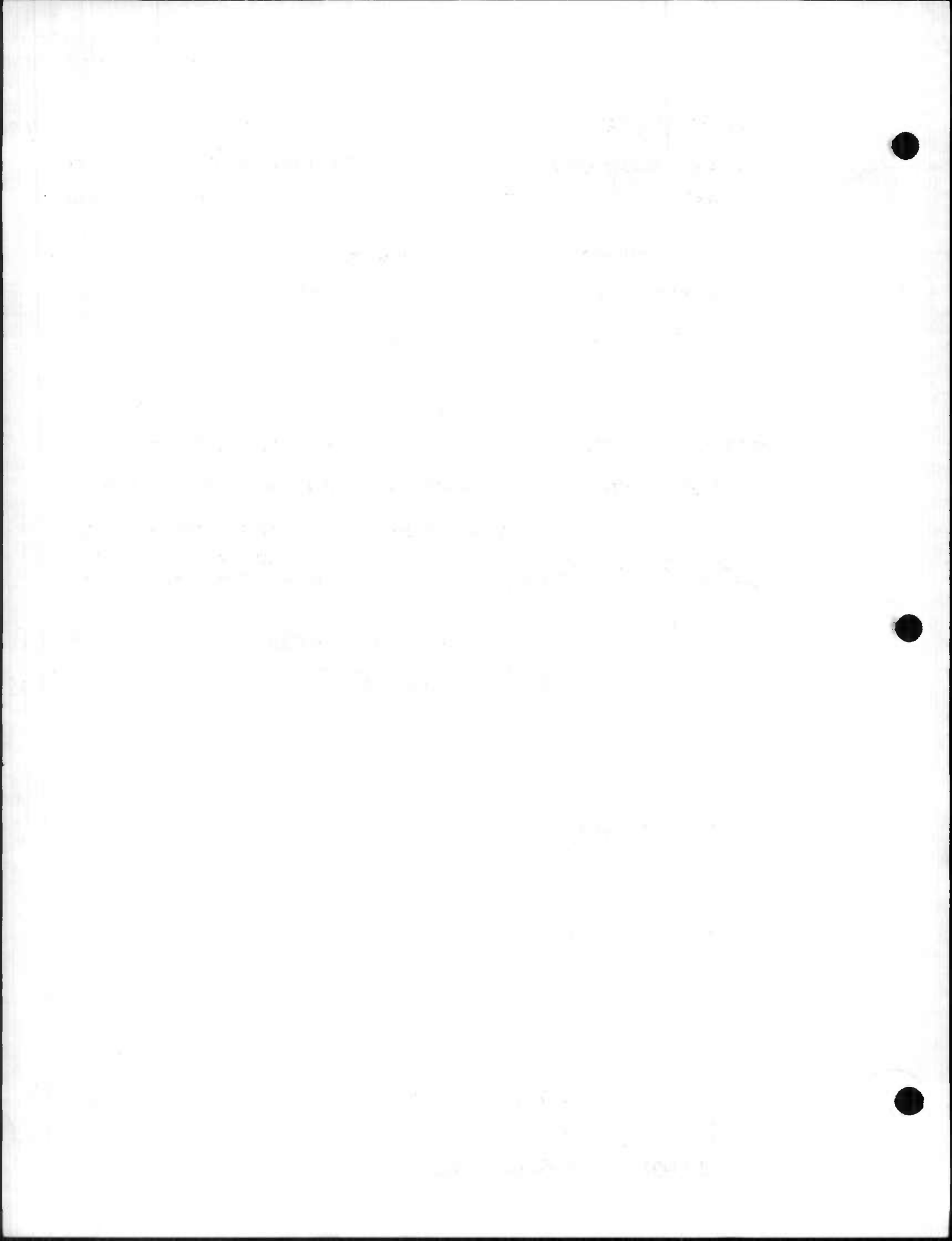
Reg. No.

22245

| | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Harry Lobe | | | | 2. Date of Death
Month July Day 18 Year 1997 | | 3. Time of Death
7:19pm | | |
| | 4a. Facility Name (If not institution, give street and number)
 Sinai Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
214-14-4641 | | 6. Sex
XX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
JUNE 5, 1918 | | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | | 10b. County
BALTIMORE | | | 10c. City, Town or Location
BALTIMORE | | | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 10e. Street and Number
1 SLADE AVENUE #301 | | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALESMAN | | | |
| 16b. Kind of Business/Industry
RETAIL | | | 17. Father's Name (First, Middle, Last)
NAPOLEON B. LOBE | | | 18. Mother's Name (First, Middle, Maiden Surname)
MAE B. BURGUNDER | | | |
| 19a. Informant's Name/Relationship (Type, Print)
LORAIN LOBE / WIFE | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 SLADE AVENUE #301 BALTIMORE, MD 21208 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BALTIMORE HEBREW | | | Date
7/21/97 | | 20c. Location - City or Town, State
REISTERSTOWN, MD | |
| 21. Signature of Funeral Service Licensee
Scott M. Gutter | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 Reisterstown Rd Pikesville, MD 21208 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p style="margin-left: 40px;">e. ventricular arrhythmia</p> <p style="margin-left: 40px;">Due to (or as a consequence of):</p> <p style="margin-left: 40px;">b. renal failure</p> <p style="margin-left: 40px;">Due to (or as a consequence of):</p> <p style="margin-left: 40px;">c. _____</p> <p style="margin-left: 40px;">Due to (or as a consequence of):</p> <p style="margin-left: 40px;">d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate interval between Onset and Death</p> <p>minutes</p> <p>three days</p> </div> </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>aortic aneurysm</p> </div> <div style="width: 25%;"> <p>23b. Did tobacco use contribute to the cause of death?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> </div> </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>24a. Was an autopsy performed?</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> </div> <div style="width: 40%;"> <p>24b. Were autopsy findings available prior to completion of cause of death?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> </div> </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>25. Was case referred to medical examiner?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> </div> <div style="width: 55%;"> <p>26. Place of Death (Check only one)</p> <p>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> </div> </div> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>27. Manner of Death</p> <p><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation</p> <p><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined</p> <p><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide</p> </div> <div style="width: 30%;"> <p>28a. Date of Injury (Month, Day, Year)</p> <p>28b. Time of Injury</p> <p>28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> </div> <div style="width: 40%;"> <p>28d. Describe how injury occurred</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> </div> </div> | | | | | | | | | |
| <p>29a. Certifier (Check only one)</p> <p><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>29b. Signature and title of certifier</p> <p>Usha Sunkara MD</p> </div> <div style="width: 30%;"> <p>29c. License number</p> <p>A02402321-MS9235</p> </div> <div style="width: 25%;"> <p>29d. Date signed (Month, Day, Year)</p> <p>July 18, 1997</p> </div> </div> | | | | | | | | | |
| <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print)</p> <p>USHA SUNKARA MD SINAI HOSPITAL, Baltimore, Maryland</p> | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p>31. Date filed (Month, Day, Year)</p> <p>JUL 23 1997</p> </div> <div style="width: 60%;"> <p>32. Registrar's Signature</p> <p>Julia Davidson-Randall</p> </div> </div> | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#16a& 16b PER F.H. FLM#G749 7/23/97

Reg. No.

97-22246

| | | | | | | | | |
|---|---|---|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CLARA LEVINE MEYER | | | | 2. Date of Death
Month JULY Day 15 Year 1997 | | 3. Time of Death
4 PM | |
| | 4e. Facility Name (If not institution, give street and number)
7008 WALLIS AVE. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
220-09-5650 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
SEPT. 14, 1915 | 9. Birthplace (State or Foreign Country)
POLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street end Number
7008 WALLIS AVE. | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ASSISTANT HOME MAKER | | | 16b. Kind of Business/Industry
OWN HOME LUMBER | |
| 17. Father's Name (First, Middle, Last)
ISAAC LEVINE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
FANNIE UNKNOWN | | | | |
| 19e. Informant's Name/Relationship (Type, Print)
SIDNEY MEYER (HUS.) | | | | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
7008 WALLIS AVE. BALTIMORE, MD 21215 | | | | |
| 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BNAI ISRAEL | | Date
7/18/97 | | 20c. Location - City or Town, State
BALTIMORE, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CALICULASTOMA
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
2 MONTHS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the causa of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street end Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | | | | | |
| | | 29c. License number
010246 | | 29d. Date signed (Month, Day, Year)
7/16/97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
23 CH SHERMAN DRIVE, OWINGS MILLS, MD 21117 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital and attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22247

| | | | | | | | | |
|---|--|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BERTHA MORSTEIN | | | | 2. Date of Death
Month JULY Day 22 Year 1997 | | 3. Time of Death
1314 Hrs | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
212-12-1803 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 5, 1916 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Owings Mills | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
8010 Upperfield Lane | | | | 10f. Zip Code
21117 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Years
College (1-4 or 5+) 2 Years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
Benjamin David Spandauer | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Irma Mann | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Nancy Morstein Boltz | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8010 Upperfield Lane Owings Mills, MD 21117 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Mausoleum | | Data
7/23/97 | | 20c. Location - City or Town, State
Pikesville, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Stephen M Jenkins</i> | | | | 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD 21133 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. UROSEPSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ISCHEMIC COLITIS | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>C. Nani MD</i> | | 29c. License number
D37333 | | 29d. Date signed (Month, Day, Year)
JULY 22, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. NANI MD, MHC, BALTO. MD 21133 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22248

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|---|---|---|--|---|--|---|--|--|--|---|---|------------------------|---------------|----------------------------|---------------|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Phillip Morris Sr. | | | | 2. Date of Death
Month 07 Day 21 Year 97 | | 3. Time of Death
1:50 PM | | | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number)
3016 Wylie Avenue | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
212-42-3784 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
54 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
9/7/42 | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
N/A | | | | | | | | | | |
| 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3016 Wylie Ave. | | 10f. Zip Code
21215 | | | | | | | | | |
| 10g. Citizen of What Country?
USA | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
Construction | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Walter Morris Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Holton | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Sandra Bolden (Sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3729 Manchester Ave. Balto. Md. 21215 | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion | | 20c. Location - City or Town, State
7/25/97 Lansdowne, Md. | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Joseph L. Russ | | | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Baltimore, Md. 21216 | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>e. Atherosclerotic Cardiovascular Disease</td> <td>Approximate Interval Between Onset and Death
25 yrs</td> </tr> <tr> <td rowspan="4">Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Pancreatitis</td> <td>30 yrs</td> </tr> <tr> <td>c. Seizure Disorder</td> <td>10 yrs</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | e. Atherosclerotic Cardiovascular Disease | Approximate Interval Between Onset and Death
25 yrs | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Pancreatitis | 30 yrs | c. Seizure Disorder | 10 yrs | d. | |
| Immediate Cause (Final disease or condition resulting in death) | e. Atherosclerotic Cardiovascular Disease | Approximate Interval Between Onset and Death
25 yrs | | | | | | | | | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Pancreatitis | 30 yrs | | | | | | | | | | | | | | | |
| | c. Seizure Disorder | 10 yrs | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Malnutrition | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | | | | | | | | | | |
| 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Tyler Cymet | | | | 29c. License number
H43157 | | 29d. Date signed (Month, Day, Year)
7/21/97 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Tyler Cymet Sinai Hospital Balto. Md. 21215 | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | | 32. Registrar's Signature
Johanna Davidson-Randall | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22249

| | | | | | | | | |
|--|---|---------------------------|---|--|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EVELYN GERTRUDE MOODY | | | | 2. Date of Death
Month JULY Day 21 Year 1997 | | 3. Time of Death
5:15 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
521-30-3732 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
AUG. 21, 1919 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
N/A | 10c. City, Town or Location
BALTIMORE CITY | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
1823 N. WASHINGTON STREET | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: NEGRO | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10TH
College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SHOWER ATTENDANT | | 16b. Kind of Business/Industry
BALTIMORE CITY PUBLIC SCHOOLS | | | |
| | 17. Father's Name (First, Middle, Last)
JOHN ROBINSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
NORA BULLOCK | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
DORIS PRIDE - niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1613 E. LAFAYETTE AVE. BALTIMORE, MD. 21213 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BALTIMORE CEMETERY | | 20c. Location - City or Town, State
JULY 25, 1997 BALTO, MD. | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO, MD. 21213 | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

END STATE CHRONIC OBSTRUCTIVE PULMONARY
e. Due to (or as a consequence of):
DISEASE

HYPERTENSION
b. Due to (or as a consequence of):

DIABETES MELLITUS
d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | | | 29c. License number
D 25886 | | 29d. Date signed (Month, Day, Year)
7. 21. 97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LILIA CEBALLOS, M.D., 7620 YORK ROAD, TOWSON, MD. 21204 | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22250

Reg. No.

| | | | | | | | | |
|---|---|---|---|---------------------------------------|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Dorothy Elizabeth Noyes</u> | | | | 2. Date of Death
Month <u>July</u> Day <u>17</u> Year <u>1997</u> | | 3. Time of Death
<u>5:30 A.M.</u> | |
| | 4e. Facility Name (If not institution, give street and number)
<u>950 Armistead Way</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>N/A</u> | |
| Funeral
Director | 5. Social Security Number
<u>214-14-7523</u> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>87</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>June 30, 1910</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | | 10a. State
<u>Maryland</u> | | 10b. County
<u>N/A</u> | | 10c. City, Town or Location
<u>Baltimore</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
<u>950 Armistead Way</u> | | 10f. Zip Code
<u>21205</u> | | 10g. Citizen of What Country?
<u>U. S. A.</u> | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>8th Grade</u> College (1-4 or 5+) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Homemaker</u> | | 16b. Kind of Business/Industry
<u>Own Home</u> | | | |
| | 17. Father's Name (First, Middle, Last)
<u>George Howard</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Mary Agnes Welch</u> | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
<u>Joseph Byard (Grandson)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>115 Ventnor Terrace, Baltimore, Maryland 21222</u> | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Oak Lawn Cemetery</u> | | Date
<u>7/19/97</u> | | 20c. Location - City or Town, State
<u>Baltimore, Maryland</u> | |
| | 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | | | 22. Name and Address of Facility
<u>Schmunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 21213</u> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <u>CONGESTIVE HEART FAILURE</u>
Due to (or as a consequence of):</p> <p>b. <u>ANAEMIA</u>
Due to (or as a consequence of):</p> <p>c. <u>RENAL FAILURE</u>
Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | | |
| | <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><u>PROBABLE G.I. MALIGNANCY</u></p> </div> <div style="width: 30%;"> <p>23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</p> </div> </div> | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
<u>[Signature]</u> | | | | 29c. License number
<u>D 15834</u> | | 29d. Date signed (Month, Day, Year)
<u>7-18-97</u> | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<u>S. Kneathman ND 3411 BANK STREET, BALTO MD 21224</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>JUL 23 1997</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1940

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22251

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR JAMES OAKLEY

2. Date of Death

Month Day Year
JULY 22 1997

3. Time of Death

0258 AM

4a. Facility Name (If not institution, give street and number)

Gibbst Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

339-22-2955

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 14, 1931

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1709 Harbinger Trail

10f. Zip Code

21040

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Barber

16b. Kind of Business/Industry

Hair Grooming

17. Father's Name (First, Middle, Last)

William Arthur Oakley

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Mary New

19a. Informant's Name/Relationship (Type, Print)

James Henry Venker (Son-in-Law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

318 Laburnum Rd. Edgewood, Md. 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens 7/24/1997

Date

20c. Location - City or Town, State

Baltimore Co., Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Brudzinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. metastatic Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

None

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25205

29d. Date signed (Month, Day, Year)

July 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley, MD GBMC 6701 N. Charles St. Balto. Md 21208

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

[Faint handwritten signature]

SEP 18 1944

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22252

| | | | | | |
|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY OGLE | | 2. Date of Death
Month July Day 19 Year 1997 | | 3. Time of Death
11:28 a.m. |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
214-14-6964 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth
Month Day Year
OCT. 24, 1919 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
N/A |
| | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
1313 E. Lafayette Ave. | | 10f. Zip Code
21213 | | |
| | 10g. Citizen of What Country?
USA | | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerk | | 16b. Kind of Business/Industry
Balto. City |
| | 17. Father's Name (First, Middle, Last)
William Hopkins | | 18. Mother's Name (First, Middle, Maiden Surname)
Lula Hopkins | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Thelma Johnson (daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1313 E. Lafayette Ave. Balto. Md. 21213 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. Zion | | 20c. Location - City or Town, State
7/25/97 Lansdowne, Md. |
| | 21. Signature of Funeral Service Licensee
Joseph L. Russ | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21214 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Brain stem infarction
Due to (or as a consequence of):
b. STATUS POST LEFT TOTAL KNEE REPLACEMENT 4 weeks
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
20 Days | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
Michael David Geschwind | | 29c. License number
Johns Hopkins Physician # 06693 | | 29d. Date signed (Month, Day, Year)
7/19/97 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Michael David Geschwind Johns Hopkins Hospital Baltimore, MD | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | 32. Registrar's Signature
Julia Davidson-Rendell | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

1875

1875

1875

1875

1875

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22253

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth D. Orange

2. Date of Death

July 21, 1997

3. Time of Death

7:00PM

4a. Facility Name (If not institution, give street and number)

Liberty Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

212-42-6525

6. Sex

Male

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 8, 1949

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

100% 200% No

10e. Street and Number

4423 Belvieu Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Consultant

16b. Kind of Business/Industry

Termix Exterminator

17. Father's Name (First, Middle, Last)

Albert G. Orange

18. Mother's Name (First, Middle, Maiden Surname)

Willia Payne

19a. Informant's Name/Relationship (Type, Print)

Albert G. Orange/father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4423 Belvieu Ave. Balto., MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

7/26

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James A. Morton & Sons Funeral Home
1701 Laurens St. Balto., MD 21217Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Massive Intracerebral Hemorrhage 4 days

Due to (or as a consequence of):

b. Substance Abuse

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George E. Wicks III M.D.

29c. License number

41365

29d. Date signed (Month, Day, Year)

July 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Wicks III M.D. 2600 Liberty Heights Ave. Balto. MD 21215

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22254

| | | | | | | | | | | |
|--|---|-------------------------------|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RICHARD JAMES PETERSEN | | | | | | 2. Date of Death
Month Day Year
JULY 16, 1997 | | 3. Time of Death
3:55 PM | |
| | 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
524 40 6082 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | | 8. Date of Birth
Month Day Year
FEB. 4, 1930 | | 9. Birthplace (State or Foreign Country)
COLORADO | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
FREDERICK | | 10c. City, Town or Location
FREDERICK | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
6109 SPRINGWATER PLACE #2202 | | | | 10f. Zip Code
21701 | | 10g. Citizen of What Country?
UNITED STATES | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ADMINISTRATOR | | | 16b. Kind of Business/Industry
EDUCATION | | |
| | 17. Father's Name (First, Middle, Last)
GEORGE PETERSEN | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
AGNES SIMONSEN | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
MARJORIE ANN PETERSEN, WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6109 SPRINGWATER PLACE, FREDERICK, MD. 21701 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARKLAWN CEMETERY | | Data
7/19/97 | | 20c. Location - City or Town, State
ROCKVILLE, MD. | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME
P.O. BOX 5038, LAYTONSVILLE, MD. 20882 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ADULT RESPIRATORY DISTRESS SYNDROME
Dua to (or as a consequence of):
b. BILATERAL PNEUMONIAS
Dua to (or as a consequence of):
c. DUODENAL ULCER HEMORRHAGE
Dua to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| | Approximate Interval Between Onset and Death
1 WEEK
2 WEEKS
3 WEEKS | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL INSUFFICIENCY, DIABETES MELLITUS
HEPATIC INSUFFICIENCY
PROTEIN MALNUTRITION | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State Registrar | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D 44580 | | 29d. Date signed (Month, Day, Year)
JULY 17, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. MARK GLOGER, 9711 MEDICAL CENTER DRIVE, ROCKVILLE, MD. 20850 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | 32. Registrar's Signature
 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22255

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John J. Pegesse

2. Date of Death

Month Day Year
July 18 97

3. Time of Death

12:28

4a. Facility Name (If not institution, give street and number)

5009 Walther Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

141-14-3663

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
07-26-13

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 2 No

10e. Street and Number

5009 Walther Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2X Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2X No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5th Grade

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Bendix Corp.

17. Father's Name (First, Middle, Last)

James

Pegesse

18. Mother's Name (First, Middle, Maiden Surname)

Sally

Simmons

19a. Informant's Name/Relationship (Type, Print)

Reigh Pegesse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5913 Loch Raven Blvd. Baltimore, Md. 21239

20a. Method of Disposition

1X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Mem. Pk. Cem. 07-24-97 Baltimore, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E. Nroth Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CORONARY ARTERY DISEASE 10 YRS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE ON HEMODIALYSISDIABETES MELLITUSPERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4X Unknown

24a. Was an autopsy performed?

1 Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2X No

25. Was case referred to medical examiner?

1 Yes 2X No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5X Residence 6 Other (Specify)

27. Manner of Death

1X Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35706

29d. Date signed (Month, Day, Year)

07/21/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Elias C. Ghandour, MD, 5601 Loch Raven Blvd., Baltimore, MD 21239

31. Date filed (Month, Day, Year)

JUL 23 1997

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97 22256

reb

1 - FOR STATE REGISTRAR Item: 6, per Physician G-749
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 7/23/97 REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. DECEASED'S NAME (First, Middle, Last)
TARIQ PATTERSON | | | | 2. DATE OF DEATH
MONTH 06 DAY 18 YEAR 97 | | 3. TIME OF DEATH
5:20 PM | |
| 4. SOCIAL SECURITY NUMBER
216-49-6381 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
0-2 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
4-1-97 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Mt. Washington Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
N/A | |
| 10a. STATE
MD. | | | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
1525 Kennewick Road | | | |
| 10f. ZIP CODE
21218 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (14 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
N/A | | 16b. KIND OF BUSINESS/INDUSTRY
N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Jerome Patterson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Tami Bethea Patterson | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jerome & Tami Patterson mother & father | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1525 Kennewick Road Baltimore, MD. 21218 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Arbutus Memorial Park | | 20c. LOCATION — City or Town, State
Balto. County, MD. | | 20d. DATE
6-24 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, MD. 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ANOXIC ENCEPHALOPATHY
DUE TO (OR AS A CONSEQUENCE OF):
b. VENTILATORY DEPENDANCE.
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death
2.5m. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> BLOTNY MD | | | | 29c. LICENSE NUMBER
D 41601 | | 29d. DATE SIGNED (Month, Day, Year)
6-18-97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
KRYSTYNA BLOTNY Mount WASHINGTON PED. HOSPITAL West - Rogers Ave. | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JUL 23 1997 | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22257

| | | | | | | | | | | | |
|--|--|--|---|--|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANN RITA REED | | | | | 2. Date of Death
Month Day Year
JULY 18, 1997 | | 3. Time of Death
12:59 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center | | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | | | |
| Funeral
Director | 5. Social Security Number
172-03-1160 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 7, 1917 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Baltimore | | 10c. City, Town or Location
Glen Arm | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
11630 Glen Arm Road | | | | | 10f. Zip Code
21057 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Claims Officer | | | 16b. Kind of Business/Industry
U.S. Government | | | |
| 17. Father's Name (First, Middle, Last)
Robert F. Weimer | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Rooney | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Thomas E. Reed (Son) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2912 Craigston Lane, Abingdon, MD. 21009 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cemetery | | | Data
7/21/97 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p align="center">PULMONARY INTERSTITIAL FIBROSIS</p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div> | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
D30263 | | 29d. Date signed (Month, Day, Year)
7-18-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS KHOO, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997
 | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22258

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Bauer Reese

2. Date of Death

Month Day Year
July 21 1997

3. Time of Death

10:10 PM

4a. Facility Name (If not institution, give street and number)

Ivy Hall Geriatric Center

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

173-03-6585

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 24, 1905

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 Edgewater Terrace

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Anton Bauer

18. Mother's Name (First, Middle, Maiden Surname)

Mary Stadler

19a. Informant's Name/Relationship (Type, Print)

Joan Thompson (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Edgewater Terrace Essex, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Joseph New Cemetery 7/24/1997

Date

20c. Location - City or Town, State

Lancaster, P.A.

21. Signature of Funeral Service Licensee

John H. Buckowski

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ADVANCED ALZHEIMER'S DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 Yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

John H. Buckowski

29c. License number

D17728

29d. Date signed (Month, Day, Year)

July 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ba Yin Oung, M.D.

8022 Belair Rd.

Balto., MD 21236

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John H. Buckowski

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text, possibly a signature or date, located at the bottom center of the page.

RECEIVED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22259

Reg. No.

| | | | | | | | | | | |
|---|--|---------------------------------|---|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John RENNER | | | | | 2. Date of Death
Month July Day 19 Year 1997 | | 3. Time of Death
1:30 p.m. | | |
| | 4e. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
212-05-4969 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 21, 1905 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
203 St. Marys Rd. | | | | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Bookkeeper | | | 16b. Kind of Business/Industry
Utility Co. | | |
| 17. Father's Name (First, Middle, Last)
Robert Renner | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Berner | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Virginia Daisy Renner | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
203 St. Marys Rd. Baltimore, Md. 21221 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | | Date
7/23/1997 | | 20c. Location - City or Town, State
Baltimore Co. Md. | | |
| 21. Signature of Funeral Service Licensee
<i>John W. Burkowski</i> | | | | | 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)
a. Right lung Pneumonia
Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death
7 days</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>D. Pann</i> | | | | | 29c. License number
A28501 | | 29d. Date signed (Month, Day, Year)
7/21/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
NAJI FAKHOURI M.D.
7638 Belair Rd.
Baltimore MD 21236 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director
 To Be Completed by Physician/Medical Examiner

91 55522

John P. Buckner

John P. Buckner

John P. Buckner

JUL 23 1951

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22260

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Russell R. Reid Sr.

2. Date of Death
Month Day Year

July 20, 1997

3. Time of Death

7:35 am

4a. Facility Name (If not institution, give street and number)

Franklin Woods Nursing Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-12-4022

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Dec. 12, 1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Highlandtown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

424 Mirabile Lane

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Crane Operator

16b. Kind of Business/Industry

Steel Co.

17. Father's Name (First, Middle, Last)

Charles Joseph Reid

18. Mother's Name (First, Middle, Maiden Surname)

Anne Daisy Weiss

19a. Informant's Name/Relationship (Type, Print)

Beulah M. Reid (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

424 Mirabile Lane Baltimore, Md. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holly Hill Mem. Gardens 7/23/1997

Date

20c. Location - City or Town, State

Baltimore, Co. Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D33943

29d. Date signed (Month, Day, Year)

7/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joan Lay RD

Franklin Square Hospital Center

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

1341

0012

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22261

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA KEY RETZER

2. Date of Death

Month
JULY

Day

19, 1997

3. Time of Death

1:45 PM

4a. Facility Name (If not institution, give street and number)

FAIRHAVEN

4b. City, Town, or Location of Death

SYKESVILLE

4c. County of Death

CARROLL

Funeral
Director

5. Social Security Number

215-10-6635

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

06-12-1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

SYKESVILLE

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

7200 THIRD AVENUE

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YEARS

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

CHARLES ELLWOOD STOCKHAM

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA YATES WILKINSON

19a. Informant's Name/Relationship (Type, Print)

SALLY KEY FISHER (DAUGH.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2901 BOSTON STREET, BALTIMORE, MD., 21224

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GREEN MOUNT CEMETERY 7-24-97 BALTO., MD., 21202

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. M. Ruth

22. Name and Address of Facility

HENRY W. JENKINS AND SONS COMPANY
4905 YORK ROAD, BALTIMORE, MARYLAND, 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

SUPRANUCLEAR PALSY

2 YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COLON CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert L. Moss, MD

29c. License number

D 32882

29d. Date signed (Month, Day, Year)

JULY 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT L. MOSS, M.D., 114 BUSINESS CENTER DRIVE, REISTERSTOWN, MD.

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John J. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

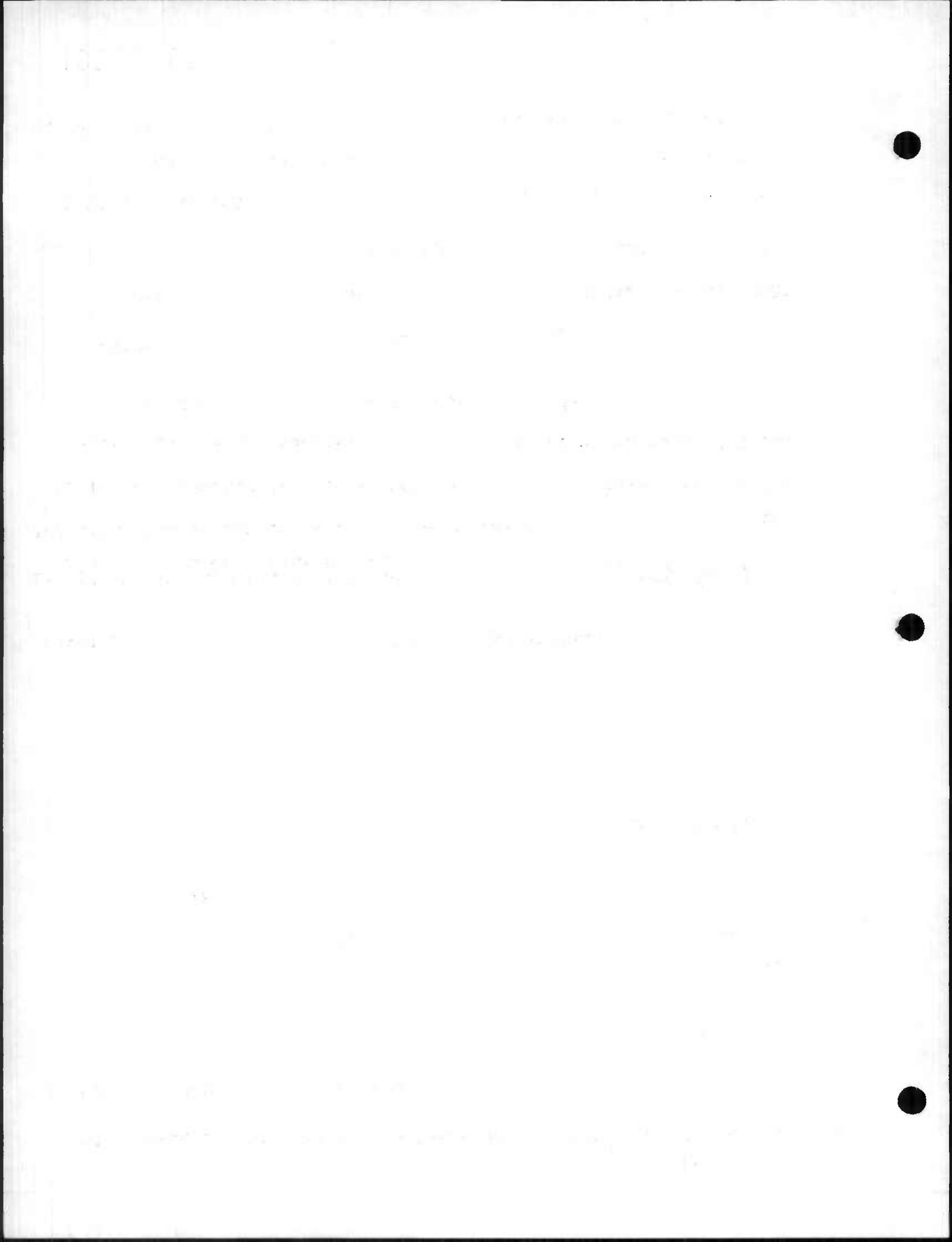
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



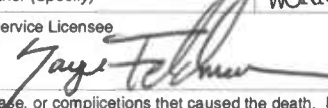
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

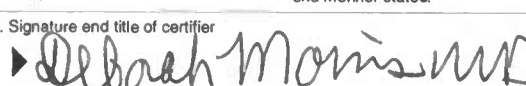
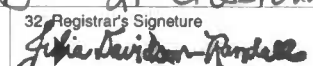
Certificate of Death

Reg. No.

97 22262

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BETTIE ROSINSKY | | | | 2. Date of Death
Month Day Year
JULY 20, 1997 | | 3. Time of Death
11:00AM | |
| | 4a. Facility Name (If not institution, give street and number)
HURWITZ HOUSE 135 SLADE AVE. 21208 | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-03-8949 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
SEPT. 19, 1906 | |
| | 9. Birthplace (State or Foreign Country)
RUSSIA | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
4003 LABYRINTH ROAD | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BUYER | | 16b. Kind of Business/Industry
DEPARTMENT STORE | | | |
| | 17. Father's Name (First, Middle, Last)
MAX ROSINSKY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ROSE RASKIN | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
BESSIE REZNICK / SISTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4003 LABYRINTH ROAD BALTIMORE, MD 21215 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WORKMEN CIRCLE | | 20c. Date
7/21/97 | | 20d. Location - City or Town, State
BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 Reisterstown Rd Pikesville, MD 21208 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. ASCVD
Due to (or as a consequence of):
b. Longstanding hypertension
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Depression, hypothyroidism, blindness | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D 31364 | | 29d. Date signed (Month, Day, Year)
7/21/97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Deborah Morris MD 21 Crossroads Dr. Owings Mills MD 21117 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

22263

1. Decedent's Name (First, Middle, Last) Lillian, Rudo 2. Date of Death July 19, 1997 3. Time of Death 8:45pm

4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore 4b. City, Town, or Location of Death Baltimore 4c. County of Death N/A

5. Social Security Number 214-20-2416 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 71 8. Date of Birth (Month, Day, Year) Dec 19, 1925 9. Birthplace (State or Foreign Country) Maryland

10a. State DE 10b. County Sussex 10c. City, Town or Location Millville 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 754 Hickman Drive 10f. Zip Code 19970 10g. Citizen of What Country? U.S.A.

11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife 16b. Kind of Business/Industry Own Home

17. Father's Name (First, Middle, Last) Isadore 18. Mother's Name (First, Middle, Maiden Surname) Rose Cornblatt

19e. Informant's Name/Relationship (Type, Print) Mr Gilbert Rudo (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 754 Hickman Drive, Millville, DE 19970

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Hebrew Friendship 20c. Location - City or Town, State Baltimore, MD

21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sol Levinson & Bros 8900 Reisterstown Rd, Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC COLON CANCER

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier SURGEY HOUSE OFFICER 29c. License number AS2402321/AC/8591 29d. Date signed (Month, Day, Year) July, 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year) JUL 23 1997 32. Registrar's Signature

Please Type or Print in Black Indelebile Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22264**
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANCES B. ROSENBLATT | | | | 2. Date of Death
Month JULY Day 16 Year 1997 | | 3. Time of Death
4 AM | |
| | 4a. Facility Name (If not institution, give street and number)
JEWISH CONVALESCENT HOME | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
111-10-4193 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
95 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 14, 1902 | |
| | 9. Birthplace (State or Foreign Country)
RUSSIA | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
7015 PARK HEIGHTS AVE. | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BROKER | | 16b. Kind of Business/Industry
INSURANCE | | | |
| | 17. Father's Name (First, Middle, Last)
MORRIS AARON HANTMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ROSE LEAH BLUMSTEIN | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MR. MATTHEW A. ROSENBLATT (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3957 McDONOGH ROAD RANDALLSTOWN, MD 21133 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CEDAR PARK | | 20c. Location - City or Town, State
7-17-97 EMERSON, NEW JERSEY | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 Reisterstown Rd Pikesville, MD 21208 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and Title of certifier

MD | | 29c. License number
115740 | | 29d. Date signed (Month, Day, Year)
7/16/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Tim Sumsit MD 6210 PK. HTS. Ave, BALT, MD 21215 | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22265

| | | | | | | | | |
|---|--|---|--|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CLARA S. RICHARDSON | | | | 2. Date of Death
Month Day Year
JULY 20, 1997 | | 3. Time of Death
5:08AM | |
| | 4a. Facility Name (If not institution, give street and number)
4605 HOMER AVENUE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
227-32-5595 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JULY 21, 1928 | | 9. Birthplace (State or Foreign Country)
VIRGINIA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
4605 HOMER AVE. | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: NEGRO | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH College (1-4or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CLERK | | | 16b. Kind of Business/Industry
SOCIAL SECURITY | |
| 17. Father's Name (First, Middle, Last)
SILAS STOKES | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LUCY JOHNSON | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ROBERT RICHARDSON - HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4605 HOMER AVE. BALTIMORE, MD. 21215 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST VET. CEM. | | | 20c. Location - City or Town, State
JULY 24, 1997 OWINGS MILLS, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
<i>Calvin B. Scruggs Jr.</i> | | | | 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON STREET BALTO, MD. 21213 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction Immediate
Due to (or as a consequence of):
b. Atherosclerosis years
Due to (or as a consequence of):
c. Hyperlipidemia years
Due to (or as a consequence of):
d. Diabetes Mellitus Type II years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RHEUMATOID ARTHRITIS | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Harry M. Walen</i> | | | | 29c. License number
D10718 | | 29d. Date signed (Month, Day, Year)
7/21/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HARRY M. WALEN MD 1838 Greene Tree Rd Ste 300 Pikesville, Maryland 21208 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22266

| | | | | | | | | | | | |
|--|--|--|---|---|---|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<div style="text-align: center;">Ida Elizabeth Silverthorn</div> | | | | | 2. Date of Death
Month Day Year
<div style="text-align: center;">July 19, 1997</div> | | 3. Time of Death
<div style="text-align: center;">8:30 PM</div> | | | |
| | 4a. Facility Name (If not institution, give street and number)
<div style="text-align: center;">St. Joseph Medical Center</div> | | | | | 4b. City, Town, or Location of Death
<div style="text-align: center;">Towson</div> | | 4c. County of Death
<div style="text-align: center;">Baltimore</div> | | | |
| Funeral
Director | 5. Social Security Number
<div style="text-align: center;">219-16-9373</div> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<div style="text-align: center;">72 Yrs.</div> | | 8. Date of Birth (Month, Day, Year)
<div style="text-align: center;">Oct. 12 1924</div> | | 9. Birthplace (State or Foreign Country)
<div style="text-align: center;">Maryland</div> | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
<div style="text-align: center;">MD</div> | | 10b. County
<div style="text-align: center;">N/A</div> | | 10c. City, Town or Location
<div style="text-align: center;">Baltimore</div> | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number
<div style="text-align: center;">6225 York Rd.</div> | | | | | 10f. Zip Code
<div style="text-align: center;">21212</div> | | 10g. Citizen of What Country?
<div style="text-align: center;">USA</div> | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <div style="text-align: center;">White</div> | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <div style="text-align: center;">12</div> College (1-4or 5+) <div style="text-align: center;">College</div> | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<div style="text-align: center;">Receptionist</div> | | | 16b. Kind of Business/Industry
<div style="text-align: center;">Constuction</div> | | | |
| 17. Father's Name (First, Middle, Last)
<div style="text-align: center;">Charles Russell</div> | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<div style="text-align: center;">Edith Bannister</div> | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<div style="text-align: center;">Bruce Russell/Brother</div> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<div style="text-align: center;">314 Parkwood St. Bethany Beach, DE. 19930</div> | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<div style="text-align: center;">Hilltop Service Co.</div> | | Date
<div style="text-align: center;">7-22-97</div> | | 20c. Location - City or Town, State
<div style="text-align: center;">Towson, MD.</div> | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
<div style="text-align: center;">Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204</div> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<div style="text-align: center;">a. <u>Drug Overdose - Paxil-Coumadin</u>
Due to (or as a consequence of):
<div style="text-align: center;">b. <u>Waldof and Cardiac Meds and anti Hypertension Rx</u>
Due to (or as a consequence of):
<div style="text-align: center;">c. <u></u>
Due to (or as a consequence of):
<div style="text-align: center;">d. <u></u></div></div></div></div> | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<div style="text-align: center;"><u>Cardio Respiratory Failure, Acute Renal Failure Rhabdomyolysis</u></div> | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year)
<div style="text-align: center;">7/16/97</div> | | 28b. Time of Injury
<div style="text-align: center;">3:00 PM</div> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred
<div style="text-align: center;">Overdose</div> | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
<div style="text-align: center;">AT Home</div> | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
<div style="text-align: center;">6225 York Rd</div> | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | | 29c. License number
<div style="text-align: center;">-09383</div> | | 29d. Date signed (Month, Day, Year)
<div style="text-align: center;">July 20, 1997</div> | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<div style="text-align: center;">Charles F. O'Donnell MD - 1114 Hamlet Hill Rd Baltimore Maryland 7/20/97</div> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<div style="text-align: center;">JUL 23 1997</div> | | | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
 To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22267

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Evans Schofield

2. Date of Death

Month Day Year
July 16, 1997

3. Time of Death

02:30PM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

218-14-8234

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 4, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12 Neves Court

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Elliott Flint Schofield

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Gatch

19a. Informant's Name/Relationship (Type, Print)

Robbin S. Englar (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Neves Court, Baltimore, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

7/24/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of palate

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16608

29d. Date signed (Month, Day, Year)

July 16, 1997

30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)

KAM KEN LEUNG, M.D., VA Maryland Health Care System, Perry Point, MD 21902

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

State
Registrar

JOHN E. SCHOFIELD

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME KNOWN TO PHYSICIAN:

Division of NAME KNOWN TO PHYSICIAN:

To the Hospital or Attending Physician: This is a statement that the death certificate has been completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be distributed for use as the burial permit.

WYNE KACOM TO LAYICICWE
JACICYNH OT WYOMI EMAN

97 22268

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Transit Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) M EUGENE SILVERT 2. Date of Death Month Day Year JULY 17, 1997 3. Time of Death 1:00 AM

4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death Towson 4c. County of Death Baltimore

5. Social Security Number 202-03-0107 6. Sex 1 M 2 F X 7. Age (In yrs. last birthday) 77 8. Date of Birth (Month, Day, Year) OCT. 29, 1919 9. Birthplace (State or Foreign Country) PENNSYLVANIA

10a. State MD 10b. County BALTIMORE 10c. City, Town or Location TIMONIUM 10d. Inside City Limits 1 X Yes 2 No

10e. Street and Number 1804 EASTRIDGE RD. 10f. Zip Code 21093 10g. Citizen of What Country? USA

11. Marital Status 1 Navar Married 2 X Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER 16b. Kind of Business/Industry MARTIN CO.

17. Father's Name (First, Middle, Last) MANUEL SILVERT 18. Mother's Name (First, Middle, Maiden Surname) ROSE JACOBY

19a. Informant's Name/Relationship (Type, Print) ANNE P. SILVERT (WIFE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1804 EASTRIDGE RD. TIMONIUM, MD 21093

20a. Method of Disposition X Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State DULANEY VALLEY MEM. GARDENS 7/21/97 TIMONIUM, MD

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC SMALL CELL LUNG CANCER

23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):

24. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 25. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

26. Was an autopsy performed? 1 Yes 2 X No 27. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

28. Was case referred to medical examiner? 1 Yes 2 X No 29. Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA 30. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify)

31. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 32. Date of Injury (Month, Day, Year) 33. Time of Injury M 34. Injury at Work? 1 Yes 2 No

35. Describe how injury occurred 36. Location (Street and Number or Rural Route Number, City or Town, State)

37. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

38. Signature and title of certifier [Signature] 39. License number D 37254 40. Date signed (Month, Day, Year) 7-18-97

41. Name and address of person who completed cause of death (Item 23e) (Type, Print) BOON P. LIM, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204

42. Date filed (Month, Day, Year) JUL 23 1997 43. Registrar's Signature [Signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22269

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Stevenson

2. Date of Death

Month Day Year
JULY 21 1997

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

218-52-4090

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 31, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2807 Jomat Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dispatcher

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Edward W. Stevenson, II

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Mitchell

19a. Informant's Name/Relationship (Type, Print)

Gail F. Stevenson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2807 Jomat Ave., Baltimore, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery

Date

7/22/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A.

6009 Harford Rd., Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardio Pulmonary Arrest

Immediate

Due to (or as a consequence of):

b. Increased Intracranial Pressure

3 months

Due to (or as a consequence of):

c. Brain Tumor

6 months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

N/A

28b. Time of
Injury

N/A

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D30060

29d. Date signed (Month, Day, Year)

7/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REGINALD J. DAVIS, M.D., 6569 N. CHARLES ST., BALTO, MD. 21204

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

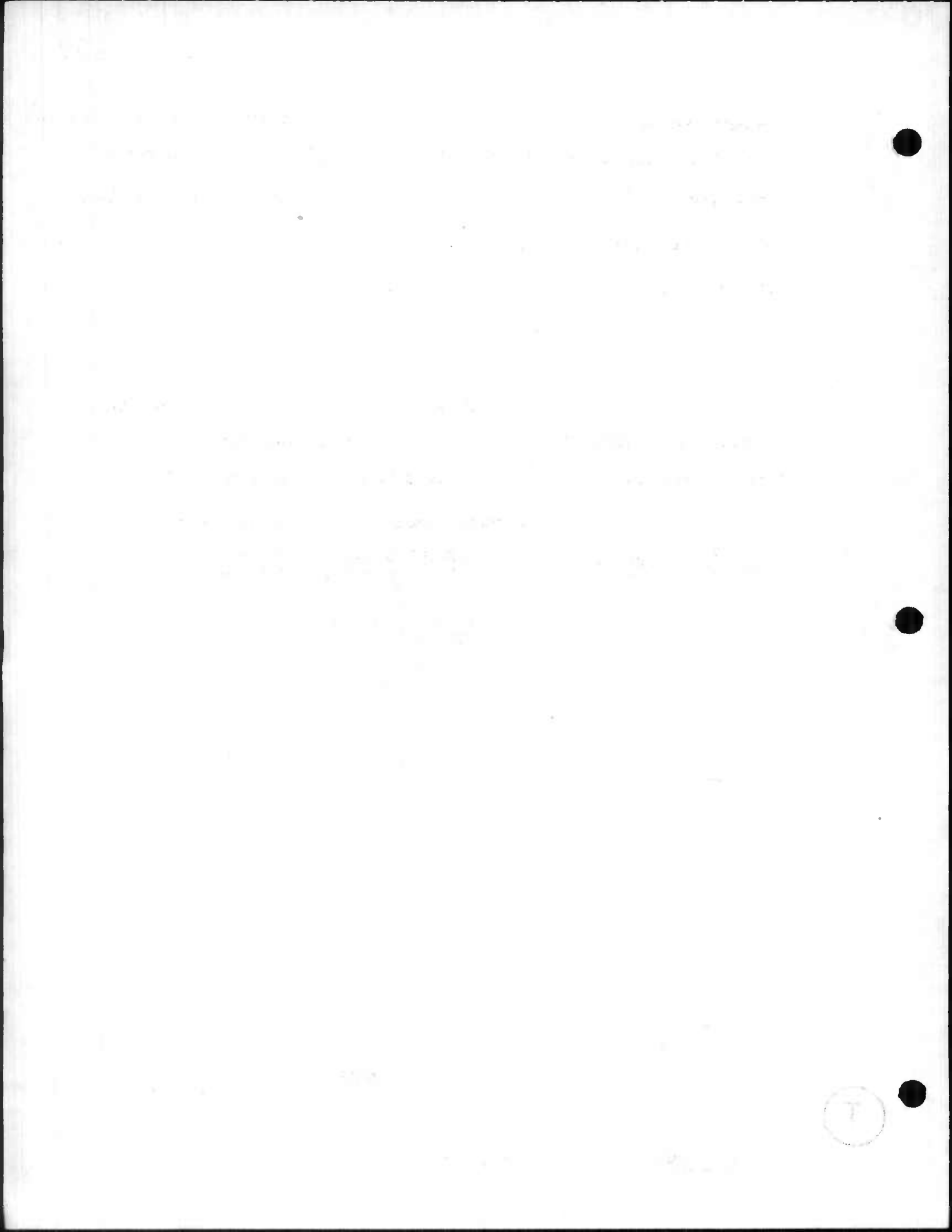
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

T



97 22270

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Bradford Carlton Sater | | | | 2. DATE OF DEATH
MONTH 07 - DAY 18 - YEAR 1997 | | 3. TIME OF DEATH
12:50 A.M. | |
| 4. SOCIAL SECURITY NUMBER
218-40-1564 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
100 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Nov. 18, 1896 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number)
The Wesley Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH
n/a | | | | 10a. STATE
Maryland | | 10b. COUNTY
n/a | |
| 10c. CITY, TOWN OR LOCATION
Baltimore | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
2211 W. Rogers Avenue | |
| 10f. ZIP CODE
21209 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW I | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Postman | | 16b. KIND OF BUSINESS/INDUSTRY
Post Office | |
| 17. FATHER'S NAME (First, Middle, Last)
Elijah Bradford Sater | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ida Cornelius | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Virginia Phillips (Daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8800 Walther Blvd. Parkville, Maryland 21234 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Saters Cemetery 7/21 | | 20c. LOCATION — City or Town, State
Chestnut Ridge, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Michael Compton</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Burgee-Henss Funeral Home, 21211 3631 Falls Road, Baltimore, Maryland | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Vascular Disease
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
Advanced Age | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, no adenocarcinoma of kidney | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>R. J. J. J. J.</i> | | | | 29c. LICENSE NUMBER
D21464 | | 29d. DATE SIGNED (Month, Day, Year)
7/21/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
3508 BANK ST. BALTO MD. 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JUL 23 1997 | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97-22271

| | | | | | | | | | | |
|--|---|--|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gary A. Tochterman | | | | | 2. Date of Death
Month July Day 20 , Year 1997 | | 3. Time of Death
10:10 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
213 Kensington Parkway | | | | | 4b. City, Town, or Location of Death
Abingdon | | 4c. County of Death
Harford | | |
| Funeral
Director | 5. Social Security Number
213-60-0246 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
43 Yrs. | | 8. Date of Birth
(Month, Day, Year)
Feb. 14, 1954 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Harford | | 10c. City, Town or Location
Abingdon | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
213 Kensington Parkway | | | | | 10f. Zip Code
21009 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Assistant Administrator | | | 16b. Kind of Business/Industry
Hospital | | | | |
| 17. Father's Name (First, Middle, Last)
George Tochterman | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sylvia Samborski | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sylvia Tochterman (mother) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
213 Kensington Parkway, Abingdon, MD 21009 | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory | | Date
7/22/97 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Rd., Bel Air, MD 21014 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. End Stage Multiple Sclerosis
Due to (or as a consequence of):</p> <p>b. _____
Due to (or as a consequence of):</p> <p>c. _____
Due to (or as a consequence of):</p> <p>d. _____
Due to (or as a consequence of):</p> </div> </div>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<div style="font-size: 1.5em; font-family: cursive;">Chronic Malnutrition</div> | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
1119171 | | 29d. Date signed (Month, Day, Year)
July 20, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
8620 Liberty Road Mail Randallstown, Maryland 21133 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22272

| | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Phyllis Jean Thornton</u> | | | | 2. Date of Death
Month <u>July</u> Day <u>18</u> Year <u>97</u> | | 3. Time of Death
<u>0635 AM</u> | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>John L. Deaton Medical Center</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>N/A</u> | | | | |
| Funeral
Director | 5. Social Security Number
<u>218-26-0381</u> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>67</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<u>April 8, 1930</u> | | | | |
| | 9. Birthplace (State or Foreign Country)
<u>Virginia</u> | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
<u>Maryland</u> | | 10b. County
<u>Baltimore</u> | | 10c. City, Town or Location
<u>Milford</u> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number
<u>3420 Abbie Place</u> | | | | 10f. Zip Code
<u>21244</u> | | 10g. Citizen of What Country?
<u>U.S.A.</u> | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12 Years</u>
College (1-4 or 5+) <u>1 Year</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Secretary</u> | | 16b. Kind of Business/Industry
<u>Baltimore Good Will, Inc</u> | | | | | |
| 17. Father's Name (First, Middle, Last)
<u>Arnold H. Kirk</u> | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Flora R. Laningham</u> | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Mr. Charles H. Thornton</u> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>3420 Abbie Place Baltimore, MD 21244</u> | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Meadowridge Memorial Park</u> | | 20c. Date
<u>7/21/97</u> | | 20d. Location - City or Town, State
<u>Elkridge, Maryland</u> | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
<u>Loring Byers Funeral Directors, Inc.</u>
<u>8728 Liberty Road Randallstown, MD 21133</u> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td style="width:50%; vertical-align: top;"> a. <u>Staphylococcal Sepsis</u>
 Due to (or as a consequence of):
 b. <u>Pneumonia</u>
 Due to (or as a consequence of):
 c. <u>Cerebrovascular Accident</u>
 Due to (or as a consequence of):
 d. </td> <td style="width:20%; vertical-align: top;"> Approximate Interval Between Onset and Death
 <u>4 days</u>
 <u>1 week</u>
 <u>5 years</u> </td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <u>Staphylococcal Sepsis</u>
Due to (or as a consequence of):
b. <u>Pneumonia</u>
Due to (or as a consequence of):
c. <u>Cerebrovascular Accident</u>
Due to (or as a consequence of):
d. | Approximate Interval Between Onset and Death
<u>4 days</u>
<u>1 week</u>
<u>5 years</u> |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <u>Staphylococcal Sepsis</u>
Due to (or as a consequence of):
b. <u>Pneumonia</u>
Due to (or as a consequence of):
c. <u>Cerebrovascular Accident</u>
Due to (or as a consequence of):
d. | Approximate Interval Between Onset and Death
<u>4 days</u>
<u>1 week</u>
<u>5 years</u> | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 28d. Describe how injury occurred | | | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
MD | | | | 29c. License number
<u>D38675</u> | | 29d. Date signed (Month, Day, Year)
<u>7/18/97</u> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<u>JOEL MESHULAM 1147 S HANOVER ST BALT MD 21230</u> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>JUL 23 1997</u> | | | | | | | | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "Natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22273

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lula Thornton

2. Date of Death

July 17th 1997

3. Time of Death

6:30 pm

4a. Facility Name (If not institution, give street and number)

BON SECOURS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-52-4787

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 01, 1946

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2511 MAISEL STREET

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

PRIVATE FAMILIES

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Summa)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

JOYCE FISHER (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2511 MAISEL STREET, BALTIMORE, MD. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

7-23-97

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

D. Brown

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE. BALTIMORE, MD. 21217

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Hepatic Encephalopathy

Due to (or as a consequence of):

b.

Renal Failure

Due to (or as a consequence of):

c.

Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

T month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. A. House Officer MD

29c. License number

D38943

29d. Date signed (Month, Day, Year)

07/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. A. House Officer MD 2600 Liberty Hgts Baltimore Maryland 21215

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22274

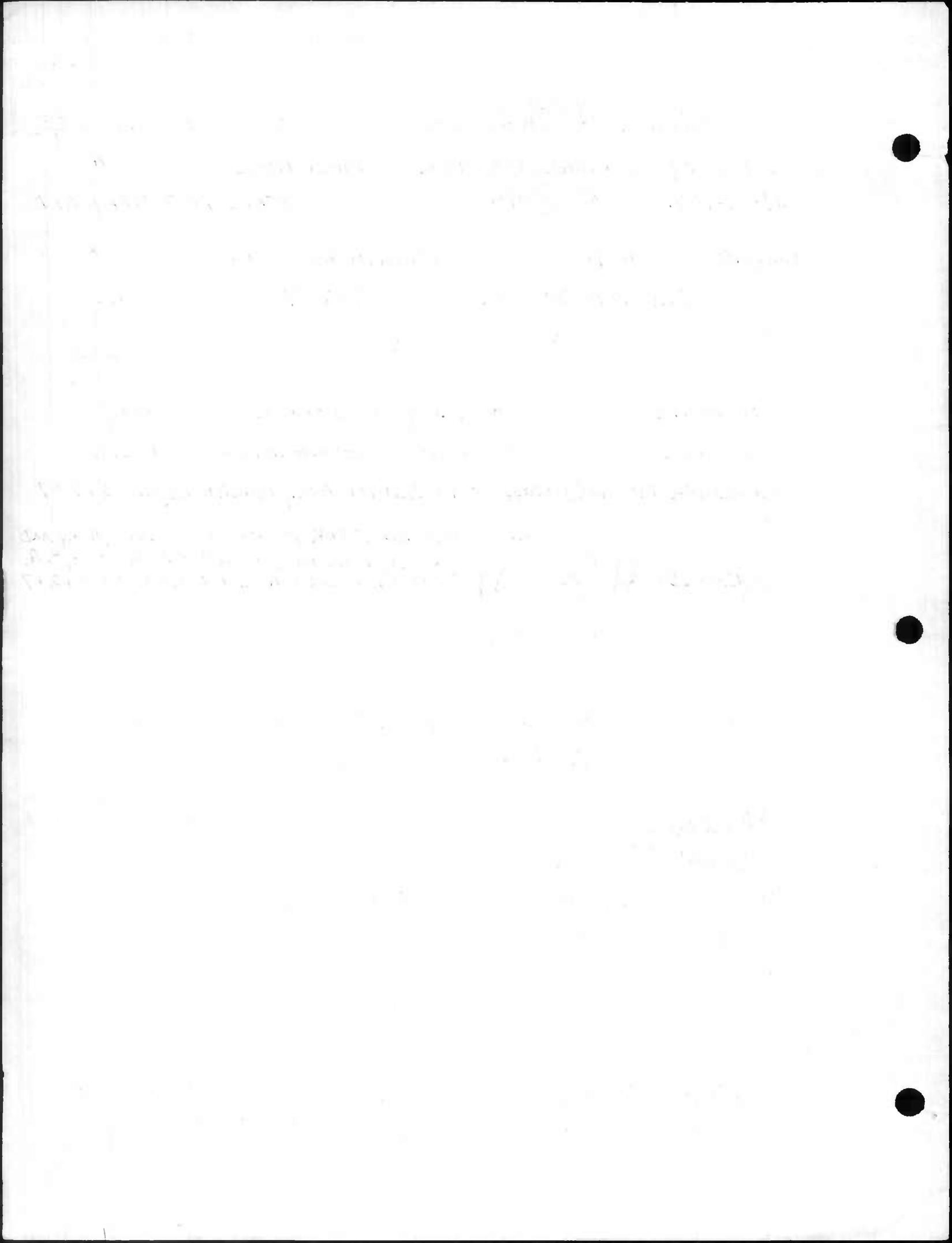
| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Sharon H. Thomas | | | | 2. Date of Death
Month July Day 16 Year 1997 | | 3. Time of Death
3 30 pm | |
| | 4a. Facility Name (If not institution, give street and number)
LIBERTY MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NIA | |
| Funeral
Director | 5. Social Security Number
217-62-1361 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
44 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 6, 1953 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
NIA | | 10c. City, Town or Location
BALTIMORE CITY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
5078 CLIFTON AVENUE | | 10f. Zip Code
21207 | |
| | 10g. Citizen of What Country?
USA. | | | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10+HGRADE College (1-4or 5+) COLLEGE | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ASSEMBLY LINE WORKER | | | | 17. Father's Name (First, Middle, Last)
JEROME THOMAS | | 18. Mother's Name (First, Middle, Maiden Surname)
GERALDINE REID | |
| To Be Completed by Physician/Medical Examiner | 19. Informant's Name/Relationship (Type, Print)
GERALDINE THOMAS (MOTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5078 CLIFTON AVE., BALTIMORE, MD, 21207 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING MEMORIAL PARK 7-21-97 WOODLAWN, MARYLAND | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE., BALTIMORE, MD, 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
SEPSIS
Due to (or as a consequence of):
ARDS
Due to (or as a consequence of):
Mycobacterium Avium Complex infection (Blood)
Due to (or as a consequence of):
AIDS | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | | |
| | 28b. Time of Injury
M | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
 | | | | 29c. License number
D45925 | | | |
| | 29d. Date signed (Month, Day, Year)
07-16-97 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHUKWUEMEKA UFOMADU, M.D.
2600 LIBERTY HEIGHTS AVENUE
BALTIMORE MD 21215 | | | |
| To Be Completed by Physician/Medical Examiner | 31. Data filed (Month, Day, Year)
JUL 23 1997 | | | | 32. Registrar's Signature
 | | | |
| | 33. Registrar's Name
John Davidson-Randall | | | | 34. Registrar's Title
Registrar | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



97 22275

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Emma Mc Iver Woody, M.D. | | | | | | 2. DATE OF DEATH
MONTH DAY YEAR
July 20, 1997 | | 3. TIME OF DEATH
4 PM M | |
| 4. SOCIAL SECURITY NUMBER
135-30-5442 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
64 YRS. | | 7. DATE OF BIRTH
MONTH DAY YEAR
May 19, 1933 | | 8. BIRTHPLACE (State or Foreign Country)
NJ | |
| 9a. FACILITY NAME (If not institution, give street and number)
1506 Dunlora Rd. | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Towson | | 9c. COUNTY OF DEATH
Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Towson | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
1506 Dunlora Rd. | | | | 10f. ZIP CODE
21204 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Physician | | 16b. KIND OF BUSINESS/INDUSTRY
Medicine | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Mc Iver Woody | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Regina Llewellyn Jones | | | |
| 19a. INFORMANT'S NAME (Type/Print)
David W. Sowa (son) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2511 Country Club Lane, Midland, Texas 79701 | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Hilltop Service Corp. | | DATE
7/22/97 | | 20c. LOCATION — City or Town, State
Towson, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Dennis C. Canall | | | | 22. NAME AND ADDRESS OF FACILITY
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Charles F. O'Donnell MD | | | | | | 29c. LICENSE NUMBER
D-09383 | | 29d. DATE SIGNED (Month, Day, Year)
July 20, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles F. O'Donnell MD - 111 Hamlet Hill Rd Baltimore 21218 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JUL 23 1997 | | | | 32. REGISTRAR'S SIGNATURE
John Davidson, Registrar | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The undersigned, the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Office of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 is marked, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22276

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN Virginia Washington

2. Date of Death

Month

Day

Year

18

1997

3. Time of Death

11:30A

Funeral
Director

4a. Facility Name (If not institution, give street and number)

CENESIS Elderhome - Crownsville

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

212-23-9196

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug 4, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1701 Eutaw Place #768

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
7th Grade

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Private Business

17. Father's Name (First, Middle, Last)

James Edward Hill

18. Mother's Name (First, Middle, Maiden Surname)

Bertha E. Walton

19a. Informant's Name/Relationship (Type, Print)

Eleanor Williams / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1733 BRADDOCK AVE BALTIMORE, MARYLAND 21216

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of
cemetery, crematory or other place)

ARBUS MEMORIAL PARK 7/24/97 ARBUS, MARYLAND

Date

7/24/97

20c. Location - City or Town, State

ARBUS, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHATHAM - HARRIS FUNERAL HOME
5540 REISTERSTOWN ROAD
BALTIMORE, MARYLAND 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

b. COMPRESSION FRACTURE OF L3 VERTEBRA

Due to (or as a consequence of):

c. SEVERE DEGENERATIVE JOINT DISEASE

Due to (or as a consequence of):

d. HYPOTHYROIDISM

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D32700

29d. Date signed (Month, Day, Year)

7/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANWAR KHOKHAR, M.D. 821 N. EUTAW ST, BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22277

Item 5 8-19-97 Film G750 W.H.Per F/H

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALLAN PETER WILLENS | | | | 2. Date of Death
Month JULY Day 15 Year 1997 | | 3. Time of Death
5:20 PM | |
| | 4a. Facility Name (If not institution, give street and number)
3810 KILBURN RD. | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
215-30-8746
215-30-8706 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
63 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAR. 7, 1934 | |
| | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
RANDALLSTOWN | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
3810 KILBURN RD. | | | | 10f. Zip Code
21133 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CLERK | | 16b. Kind of Business/Industry
SOCIAL SEC. ADMN. | |
| | 17. Father's Name (First, Middle, Last)
NATHAN WILLENS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
PAULINE ZIEGER | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
MRS. PHYLLIS GOLDBERG (SISTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8015 VALLEY MANOR RD., APT. 2-B OWINGS MILLS, MD 21117 | | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOSES MONTEFIORE WOODMOOR HEBREW | | Date
7/17/97 | | 20c. Location - City or Town, State
BALTO., MD | |
| | 21. Signature of Funeral Service Licensee
<i>Allen Sue Leverson</i> | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Cardio Respiratory Failure
Due to (or as a consequence of):
Grade III Heart Failure
Due to (or as a consequence of):
Arteriosclerotic Cardio Vascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 10 IVA | 29b. Signature and title of certifier
<i>Charles F. O'Donnell</i> | | | | 29c. License number
D-09383 | | 29d. Date signed (Month, Day, Year)
July 16, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Charles F. O'Donnell MD - 111 Hamlet Hill Rd Maryland 21210 | | | | | | | |
| Physician
/Medical
Examiner | 31. Date filed (Month, Day, Year)
JUL 23 1997 | | | | 32. Registrar's Signature
<i>Julia Davidson</i> | | | |
| | 33. Registrar's Name
Julia Davidson | | | | | | | |

Baltimore, Maryland 21215-0020

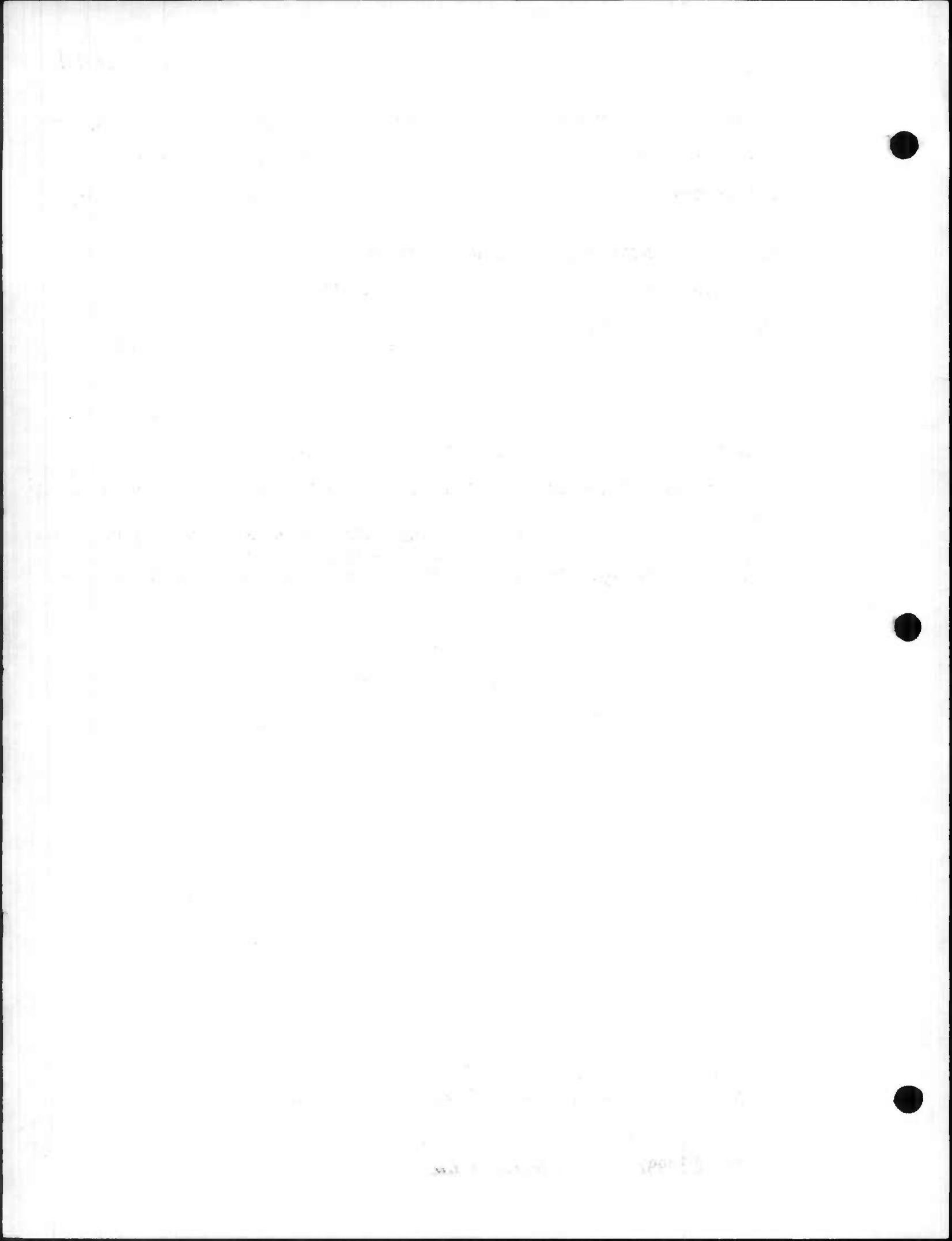
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22278

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ethel Allen | | | | 2. Date of Death
Month Day Year
July 16, 1997 | | 3. Time of Death
4:00 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
831 N. Augusta Avenue | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
218-12-2497 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
3-18-1915 | | 9. Birthplace (State or Foreign Country)
Va |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md | 10b. County
NA | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
831 N. Augusta Avenue | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th grade College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Geriatric Nurse | | 16b. Kind of Business/Industry
Medical | | | |
| | 17. Father's Name (First, Middle, Last)
Willie Nelson | | | 18. Mother's Name (First, Middle, Maiden Surname)
Della | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Ruby Travis - Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 Church Lane Balto, Md 21208 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Men Park | | Date
7-22-97 | | 20c. Location - City or Town, State
Balto, Md | |
| | 21. Signature of Funeral Service Licensee
Gabrielle Cooper | | | 22. Name and Address of Facility
March F.H. West
4300 Wabash Avenue Balto, Md 21215 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immadiate Cause (Final disease or condition resulting in death)
a. Alzheimers Disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary Fibrosis | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Michael W. ... | | 29c. License number
030433 | | 29d. Date signed (Month, Day, Year)
7/23/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
2200 KERNAN DRIVE BALTIMORE MD 21207 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Item 16a per FH Film G749 7-25-97 rja

Certificate of Death

Reg. No.

22279

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Addie

Odell

Brown

2. Date of Death

Month

Day

Year

3. Time of Death

10 05 pm

4a. Facility Name (If not institution, give street and number)

JOSEPH RITCHIE HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

212-46-2282

6. Sex

1 ☒ M ☐ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

FEB. 14, 1946

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

828 N. EUTAW STREET

10f. Zip Code

21223

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (13-16)

College (17-19)

College (20-24)

College (25-29)

College (30-34)

College (35-39)

College (40-44)

College (45-49)

College (50-54)

College (55-59)

College (60-64)

College (65-69)

College (70-74)

College (75-79)

College (80-84)

College (85-89)

College (90-94)

College (95-99)

College (100-104)

College (105-109)

College (110-114)

College (115-119)

College (120-124)

College (125-129)

College (130-134)

College (135-139)

College (140-144)

College (145-149)

College (150-154)

College (155-159)

College (160-164)

College (165-169)

College (170-174)

College (175-179)

College (180-184)

College (185-189)

College (190-194)

College (195-199)

College (200-204)

College (205-209)

College (210-214)

College (215-219)

College (220-224)

College (225-229)

College (230-234)

College (235-239)

College (240-244)

College (245-249)

College (250-254)

College (255-259)

College (260-264)

College (265-269)

College (270-274)

College (275-279)

College (280-284)

College (285-289)

College (290-294)

College (295-299)

College (300-304)

College (305-309)

College (310-314)

College (315-319)

College (320-324)

College (325-329)

College (330-334)

College (335-339)

College (340-344)

College (345-349)

College (350-354)

College (355-359)

College (360-364)

College (365-369)

College (370-374)

College (375-379)

College (380-384)

College (385-389)

College (390-394)

College (395-399)

College (400-404)

College (405-409)

College (410-414)

College (415-419)

College (420-424)

College (425-429)

College (430-434)

College (435-439)

College (440-444)

College (445-449)

College (450-454)

College (455-459)

College (460-464)

College (465-469)

College (470-474)

College (475-479)

College (480-484)

College (485-489)

College (490-494)

College (495-499)

College (500-504)

College (505-509)

College (510-514)

College (515-519)

College (520-524)

College (525-529)

College (530-534)

College (535-539)

College (540-544)

College (545-549)

College (550-554)

College (555-559)

College (560-564)

College (565-569)

College (570-574)

College (575-579)

College (580-584)

College (585-589)

College (590-594)

College (595-599)

College (600-604)

College (605-609)

College (610-614)

College (615-619)

College (620-624)

College (625-629)

College (630-634)

College (635-639)

College (640-644)

College (645-649)

College (650-654)

College (655-659)

College (660-664)

College (665-669)

College (670-674)

College (675-679)

College (680-684)

College (685-689)

College (690-694)

College (695-699)

College (700-704)

College (705-709)

College (710-714)

College (715-719)

College (720-724)

College (725-729)

College (730-734)

College (735-739)

College (740-744)

College (745-749)

College (750-754)

College (755-759)

College (760-764)

College (765-769)

College (770-774)

College (775-779)

College (780-784)

College (785-789)

College (790-794)

College (795-799)

College (800-804)

College (805-809)

College (810-814)

College (815-819)

College (820-824)

College (825-829)

College (830-834)

College (835-839)

College (840-844)

College (845-849)

College (850-854)

College (855-859)

College (860-864)

College (865-869)

College (870-874)

College (875-879)

College (880-884)

College (885-889)

College (890-894)

College (895-899)

College (900-904)

College (905-909)

College (910-914)

College (915-919)

College (920-924)

College (925-929)

College (930-934)

College (935-939)

College (940-944)

College (945-949)

College (950-954)

College (955-959)

College (960-964)

College (965-969)

College (970-974)

College (975-979)

College (980-984)

College (985-989)

College (990-994)

College (995-999)

College (1000-1004)

College (1005-1009)

College (1010-1014)

College (1015-1019)

College (1020-1024)

College (1025-1029)

College (1030-1034)

College (1035-1039)

College (1040-1044)

College (1045-1049)

College (1050-1054)

College (1055-1059)

College (1060-1064)

College (1065-1069)

College (1070-1074)

College (1075-1079)

College (1080-1084)

College (1085-1089)

College (1090-1094)

College (1095-1099)

College (1100-1104)

College (1105-1109)

College (1110-1114)

College (1115-1119)

College (1120-1124)

College (1125-1129)

College (1130-1134)

College (1135-1139)

College (1140-1144)

College (1145-1149)

College (1150-1154)

College (1155-1159)

College (1160-1164)

College (1165-1169)

College (1170-1174)

College (1175-1179)

College (1180-1184)

College (1185-1189)

College (1190-1194)

College (1195-1199)

College (1200-1204)

College (1205-1209)

College (1210-1214)

College (1215-1219)

College (1220-1224)

College (1225-1229)

College (1230-1234)

College (1235-1239)

College (1240-1244)

College (1245-1249)

College (1250-1254)

College (1255-1259)

College (1260-1264)

College (1265-1269)

College (1270-1274)

College (1275-1279)

College (1280-1284)

College (1285-1289)

College (1290-1294)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22280

| | | | | | | |
|--|---|--|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPH BISHOP, SR. | | 2. Date of Death
Month Day Year
JULY 20, 1997 | | 3. Time of Death
12:55 AM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
214 20 9729 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | |
| | 8. Date of Birth (Month, Day, Year)
SEPT. 25, 1925 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | |
| | 10a. State
MD. | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | |
| | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number
1 WALDEN OAK COURT | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
U.S. OF A. | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 11/26/43 4/14/46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11TH
College (1-4 or 5+) UNKNOWN | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MAIL CARRIER | | 16b. Kind of Business/Industry
U.S. POST OFFICE | |
| | 17. Father's Name (First, Middle, Last)
JOSEPH H BISHOP | | 18. Mother's Name (First, Middle, Maiden Surname)
ELLA R. PURVINES BISHOP | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
JOSEPH W. BISHOP, JR. (SON) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 WALDEN OAK COURT BALTO., MD. 21207 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST VET. CEM. | | 20c. Location - City or Town, State
BALTO. OWINGS MILLS, MD. CO. | |
| 21. Signature of Funeral Service Licensee
Lewis T. Gwynn | | 22. Name and Address of Facility
LEWIS T. GWYNN FUNERAL HOME 21215-6393
4517 PARK HEIGHTS AVE. BALTO., MD. | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

RENAL FAILURE
Due to (or as a consequence of):
CARDIOMYOPATHY
Due to (or as a consequence of):
SEPSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
STATUS EPILEPTICUS
VILLOUS ADENOMA COLON | | | | | 23b. Did tobacco use contribute to the causa of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of causa of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
M | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
John F. [Signature] | | 29c. License number
D27157 | |
| | 29d. Date signed (Month, Day, Year)
JULY 20, 1997 | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAYNOLD DEPESTRE NORTHWEST HOSPITAL CENTER | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 24 1997 | | 32. Registrar's Signature
John Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1911

1. The first part of the report is devoted to a general survey of the situation in the country. It is found that the country is in a state of general depression, and that the people are suffering from want and distress. The cause of this is attributed to the war, and the consequent destruction of property and the loss of life.

2. The second part of the report is devoted to a detailed account of the various districts of the country. It is found that the districts are all in a state of general depression, and that the people are suffering from want and distress. The cause of this is attributed to the war, and the consequent destruction of property and the loss of life.

3. The third part of the report is devoted to a detailed account of the various districts of the country. It is found that the districts are all in a state of general depression, and that the people are suffering from want and distress. The cause of this is attributed to the war, and the consequent destruction of property and the loss of life.

4. The fourth part of the report is devoted to a detailed account of the various districts of the country. It is found that the districts are all in a state of general depression, and that the people are suffering from want and distress. The cause of this is attributed to the war, and the consequent destruction of property and the loss of life.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEM#20a&20b PER F.H. FILM#G749 7/24/97 J.A.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Katherine L. Baseman
2. Date of Death Month Day Year JULY 21, 1997
3. Time of Death 7:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSN
4b. City, Town, or Location of Death GLEN BURNIE
4c. County of Death ANNE ARUNDEL

5. Social Security Number 220-92-8095
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 34 Yrs.
8. Date of Birth (Month, Day, Year) May 19, 1963
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent

10a. State Maryland
10b. County Anne Arundel
10c. City, Town or Location Glen Burnie
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 7883 Tall Pines Ct., Apt. C
10f. Zip Code 21061
10g. Citizen of What Country? United States

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk
16b. Kind of Business/Industry Lithography

17. Father's Name (First, Middle, Last) Joseph Raley
18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Stickel

19a. Informant's Name/Relationship (Type, Print) Jerry Allen Baseman, Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7883 Tall Pines Ct., Apt. C, Glen Burnie, MD 21061

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ENTOMBMENT
20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY
20c. Location - City or Town, State Baltimore, Maryland
20d. Date of Disposition July 25, 1997

21. Signature of Funeral Service Licensee
22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Cardiac Arrhythmia Due to (or as a consequence of):
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Cardiomyopathy Due to (or as a consequence of): 12 years
g. Valvular Heart disease Due to (or as a consequence of): 12 years
h. Marfan's Syndrome

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II - Atrioventricular Block
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Kevin Doyle MD
29c. License number D31122
29d. Date signed (Month, Day, Year) 7/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Doyle, MD, 203 Hospital Drive, Suite 206, Glen Burnie, MD 21060

31. Date filed (Month, Day, Year) JUL 24 1997
32. Registrar's Signature Julia Anderson-Randall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

VOID

DEATH

certificate no.: 97- 22282

97-4058-510

CMK

ANTHONY CURTIS

Items: 23a part I, 27 per MEO G-750 8/6/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22283

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Anthony Curtis

2. Date of Death

Month Day Year
JULY 21, 1997

3. Time of Death

0412AM

4a. Facility Name (If not institution, give street and number)

5005 PALMER AVENUE

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

215-84-2783

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 18, 1960

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5005 Palmer Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th gradeCollege (1-4 or 5+)
N/A

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Private Nursing

16b. Kind of Business/Industry

State of Md

17. Father's Name (First, Middle, Last)

Clifton Curtis

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Taylor

19a. Informant's Name/Relationship (Type, Print)

Margaret Taylor-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5005 Palmer Avenue Baltimore, Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

7/25/97

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

Gabrielle Cook

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MORBID OBESITY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22284

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Frances M. Dare | | | | 2. Date of Death
Month Day Year
July 19, 1997 | | 3. Time of Death
10:45 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
2521 Reisterstown Road | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-14-0395 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
4-26-1925 | |
| | 9. Birthplace (State or Foreign Country)
D.C. | | 10a. State
Md | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2521 Reisterstown Road | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
U S A | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
9th grade | | Collage (1-4 or 5+)
N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic | | 16b. Kind of Business/Industry
Home | |
| | 17. Father's Name (First, Middle, Last)
James Elliott | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elsie Elliott | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Charles Elliott - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2521 Reisterstown Road Baltimore, Md 21217 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park | | Data
7-25-97 | | 20c. Location - City or Town, State
Arbutus, Md | |
| | 21. Signature of Funeral Service Licensee
Gabrielle Cook | | | | 22. Name and Address of Facility
March F/H West
4300 Wabash Avenue Baltimore, Md 21215 | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Cardio-Vascular disease
Due to (or as a consequence of):
b. Atherosclerosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebro-vascular disease | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
Amatun M. Nassim M.D. | | | | 29c. License number
DISS03 | | 29d. Date signed (Month, Day, Year)
July, 23, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
501 Dolphin St, Baltimore MD 21217 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | 32. Registrar's Signature
John Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

57 22285

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Harrison Dieter, Sr.

2. Date of Death

July 16, 1997 1 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

516 1/2 Hampton Lane

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore County

Funeral
Director

5. Social Security Number

217-05-5713

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 11, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Towson

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

516 1/2 Hampton Lane

10f. Zip Code

21286

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates: Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

John W. Dieter

18. Mother's Name (First, Middle, Maiden Surname)

Anna Marie Hasse

19a. Informant's Name/Relationship (Type, Print)

John H. Dieter, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8910 Emla Avenue, Baltimore, Maryland 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Quanta R Thomas

22. Name and Address of Facility

John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

38 Cal Pistol Wound To Head

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cancer of Prostate
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☒ Yes ☐ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending Investigation
☒ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month Day Year)

7/16/97

28b. Time of Injury

1:00 PM

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

38 Cal Pistol To Temple
516 1/2 Hampton Lane
Towson, MD 21286

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Charles F. O'Donnell MD

29c. License number

1-09383

29d. Date signed (Month, Day, Year)

July 23, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles F. O'Donnell MD - 111 Hamlet Hill Rd Baltimore Maryland 21218

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Registrar: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22286

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Leroy Dietz Jr.

2. Date of Death

Month Day Year
July 21 1997

3. Time of Death

0810 PM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-36-1316

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 30, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1103 Meadowlark Drive

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
☐ Yes ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☒ Yes ☐ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Private Investigator

16b. Kind of Business/Industry

Service

17. Father's Name (First, Middle, Last)

Thomas Leroy Dietz Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Wensein

19a. Informant's Name/Relationship (Type, Print)

Barbara J. Dietz, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1103 Meadowlark Drive Arbutus, Maryland 21227

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

7/26

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc.
1328 Sulphur Spring RoadArbutus
2122723a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Hepatorenal syndrome

Due to (or as a consequence of):

weeks

b. Cirrhosis of the liver

Due to (or as a consequence of):

years

c. Alcoholism

Due to (or as a consequence of):

years

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☒ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
injury

M

28c. Injury at
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D43453

29d. Date signed (Month, Day, Year)

July 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. Dixon King, Jr. - St. Agnes HealthCare - 900 Caton Avenue, Baltimore, Md. 21229

31. Date filed (Month, Day, Year)

JUL 24 1997

Registrar's Signature

State
Registrar

Thomas L. Dietz

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22287

| | | | | | | | | |
|---|--|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM I. FALLON JR. | | | | 2. Date of Death
Month JULY 19 Day 19 Year 1997 | | 3. Time of Death
9:20 PM | |
| | 4a. Facility Name (If not institution, give street and number)
17520 QUEEN ELIZABETH DRIVE | | | | 4b. City, Town, or Location of Death
OLNEY | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
178 30 5057 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN. 19, 1937 | |
| | 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | | 10a. State
MD. | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
OLNEY | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
17520 QUEEN ELIZABETH DRIVE | | 10f. Zip Code
20832 | | 10g. Citizen of What Country?
UNITED STATES | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CORPORATE MANAGER | | 16b. Kind of Business/Industry
SATELLITE COMMUNICATIONS | | | | |
| 17. Father's Name (First, Middle, Last)
WILLIAM I. FALLON, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
HELEN GOSNEAR | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
PHYLLIS C. FALLON, WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17520 QUEEN ELIZABETH DRIVE, OLNEY, MD. 20832 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GATE OF HEAVEN CEMETERY | | 20c. Location - City or Town, State
7/23/97 SILVER SPRING, MD. | | 20d. Date | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME
PO BOX 5038 LAYTONSVILLE, MD. 20882 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. BLADDER CANCER, METASTATIC
Dua to (or as a consequence of):

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 ATTENDING PHYSICIAN | | | | 29c. License number
D34740 (MD) | | 29d. Date signed (Month, Day, Year)
JULY 21, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT FIEUSS, MD 1811 PRINCE PHILIP DR, T-12; OLNEY, MD 20832 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22288

| | | | | | | | | |
|---|--|---|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Erlin L. Freeman | | | | 2. Date of Death
Month Day Year
July 19, 1997 | | 3. Time of Death
10:40AM | |
| | 4a. Facility Name (If not institution, give street and number)
1236 Oakland Terrace Road | | | | 4b. City, Town, or Location of Death
Arbutus | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
234-12-8757 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 9, 1917 | |
| | 9. Birthplace (State or Foreign Country)
West Virginia | | Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Arbutus | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
1236 Oakland Terrace Road | | | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | | 16b. Kind of Business/Industry
Radar Testing | |
| 17. Father's Name (First, Middle, Last)
Aubrey Guy Freeman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dicie Keys | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Genevieve V. Freeman Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1236 Oakland Terrace Rd. Arbutus, MD 21227 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Masonic Memorial Park | | 20c. Location - City or Town, State
West West Union Virginia | | |
| 21. Signature of Funeral Service Licensee
<i>Paul D. Hagan</i> | | | | 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Road
Arbutus, Maryland 21227 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Cardio vascular arrest
b. Sepsis
c. End stage of Dementia
d. | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>H. TAVASSOLIAN</i> | | 29c. License number
D18484 | | 29d. Date signed (Month, Day, Year)
7/21/97 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
H. TAVASSOLIAN MD 3455 WILKENS AVE #306 BALT. MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22289

Item 27 Per PHY Film G749 7-25-97 rja

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---------------------------------------|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Doris Lee Graham | | | | 2. Date of Death
Month Day Year
July 8, 1997 | | 3. Time of Death
9:10 PM | | |
| | 4e. Facility Name (If not institution, give street and number)
603 Hillview Road | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
212-24-8209 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
06-21-23 | 9. Birthplace (State or Foreign Country)
MD | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
603 Hillview Road | | | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 18e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Medical Coder | | 16b. Kind of Business/Industry
Federal Government | | | |
| 17. Father's Name (First, Middle, Last)
Charles Walker Booth | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Whiting | | | | | |
| 19e. Informant's Name/Relationship (Type, Print)
Janet West/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
603 Hillview Road, Baltimore, Maryland 21225 | | | | | |
| 20e. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee
<i>Ronald S. Wade</i> 7/10/97 | | | | 22. Name and Address of Facility
Maryland Baltimore, Maryland 21201 | | | | | |
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death)
a. metastatic breast cancer
Due to (or as a consequence of): | | | | | | | | 12 year | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): | | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Ronald S. Wade</i> | | | | 29c. License number
D22782 | | 29d. Date signed (Month, Day, Year)
7/14/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Aron W. Berkman, M.D. 3001 S. Hanover St. Balt. Md. 21225 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

all date

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22290

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|---|----|--|--|----|--|----|--|----|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lydia D. Gorman | | | | 2. Date of Death
Month Day Year
July 23, 1997 | | 3. Time of Death
9:45 A.M. | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
7102 Pickering Ct. | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
161-56-4806 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
38 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 3, 1959 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Glen Burnie | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| | 10e. Street and Number
7102 Pickering Ct. | | | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
United States | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Office | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Raymond Hughes | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Helen Gardner | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Ronald A. Gorman | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7102 Pickering Ave., Glen Burnie, Maryland 21061 | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Royer Cemetery | | Data
July 26, 1997 | | 20c. Location - City or Town, State
Royer, Pennsylvania | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, MD 21061 | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Adenocarcinoma of the Breast, metastatic</td> <td rowspan="4">Approximate Interval Between Onset and Death
1 1/2 year</td> </tr> <tr> <td>b.</td> <td></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Adenocarcinoma of the Breast, metastatic | Approximate Interval Between Onset and Death
1 1/2 year | b. | | c. | | d. |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Adenocarcinoma of the Breast, metastatic | Approximate Interval Between Onset and Death
1 1/2 year | | | | | | | | | | | | | | |
| | b. | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number
D42979 | | 29d. Date signed (Month, Day, Year)
July 23, 1997 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael A. Carducci, M.D., 600 N. Wolfe St., Baltimore, Maryland | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | 32. Registrar's Signature
Julia Gordon-Randall | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

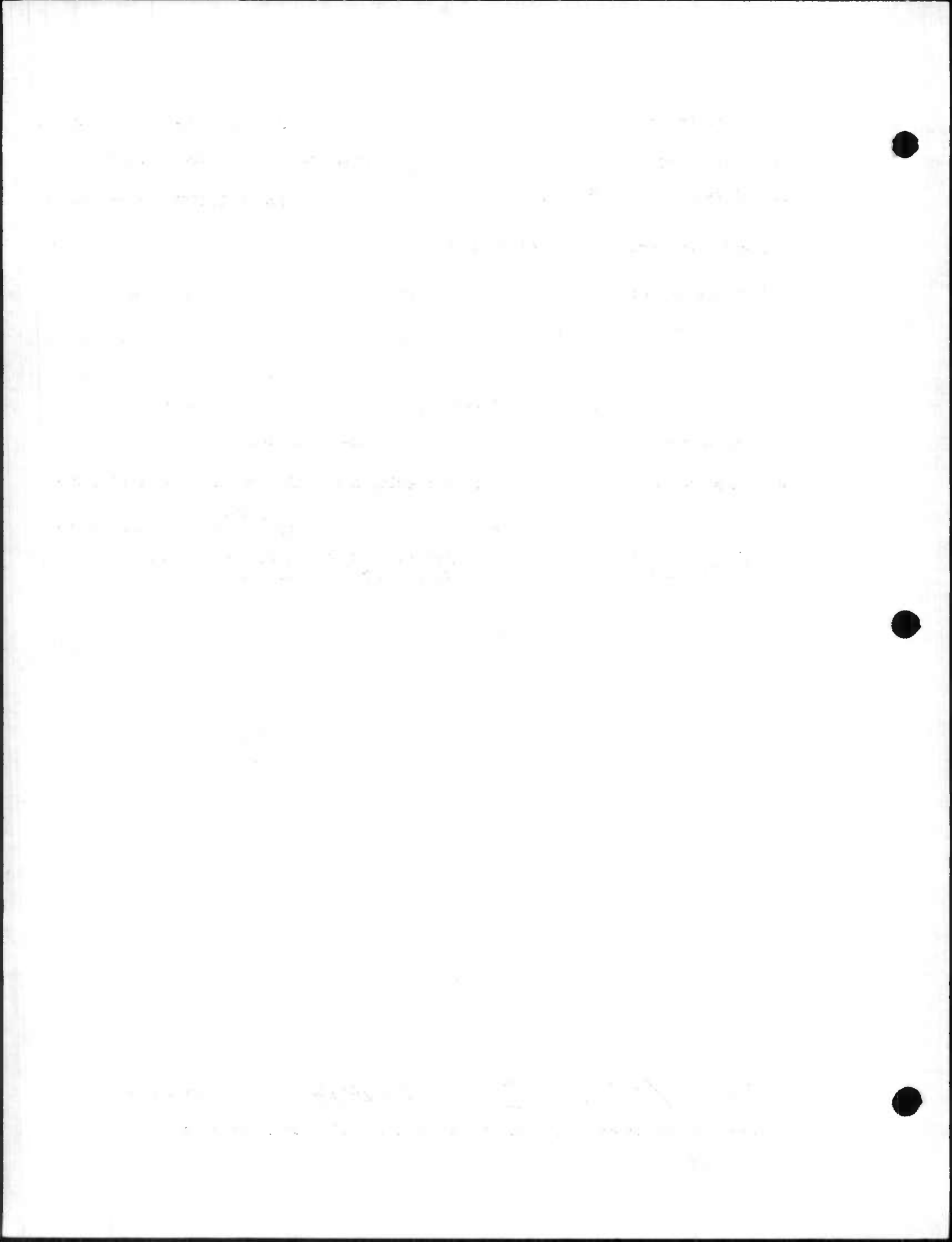
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22291

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
ELIZABETH HILL | | | | 2. Date of Death
Month JULY Day 22 Year 1997 | | 3. Time of Death
23:19 | |
| 4a. Facility Name (If not institution, give street and number)
Sinai Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | |
| 5. Social Security Number
212-22-7653 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth
Month, Day, Year
3-19-1908 | |
| 9. Birthplace (State or Foreign Country)
S.C. | | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
4509 Groveland Avenue | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unknown College (14 or 5+) Unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | 17. Father's Name (First, Middle, Last)
Henry A. Grant | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Maggie L. Grant | | 19a. Informant's Name/Relationship (Type, Print)
Calvin Hill - Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10300 Walker Lake Drive Great Falls, Va 22066 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Zion Hill Church Cem | | 20c. Date
7-28-97 | | 20d. Location - City or Town, State
Cross Hill, S.C. | | 21. Signature of Funeral Service Licensee
Gabriele Cook | |
| 22. Name and Address of Facility
March H. West 4300 Wabash Avenue Baltimore, MD 21215 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
AORTIC DISSECTION
Due to (or as a consequence of):
HYPERTENSION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
ONE DAY YEARS | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Blaine L. Lussman, MD | |
| 29c. License number
D44841 | | 29d. Date signed (Month, Day, Year)
JULY 22, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARC SUSSMAN MD 600 N. WOLFEST, BALTIMORE, MARYLAND | | 31. Date filed (Month, Day, Year)
JUL 24 1997 | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22292

| | | | | | |
|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Silas Hopkins | | 2. Date of Death
Month July Day 21 Year 97 | | 3. Time of Death
1:20am |
| | 4a. Facility Name (If not institution, give street and number)
2229 Homewood Avenue | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA |
| Funeral
Director | 5. Social Security Number
246-14-6991 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
03-05-21 | | 9. Birthplace (State or Foreign Country)
NC | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Md | | 10b. County
NA |
| | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
2229 Homewood Avenue | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Welder | | 16b. Kind of Business/Industry
in & Out of Home | | |
| | 17. Father's Name (First, Middle, Last)
Jesse Hopkins | | 18. Mother's Name (First, Middle, Maiden Surname)
Hattie Langley | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Beulah Hopkins | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2229 Homewood Avenue Baltimore, Maryland 21218 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 07-26-97 | | 20c. Location - City or Town, State
Woodlawn, Md. |
| | 21. Signature of Funeral Service Licensed
 | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Interstitial lung Disease
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
~ decade |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease
Diabetes mellitus | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D40609 | | 29d. Date signed (Month, Day, Year)
7/23/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Janice Ryan, MD - No. Point Medical Ctr., 1005 No. Point Blvd-Suite 700, Balt, MD 21224 | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The undersigned certifies that the death certificate was executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22293

Items: 4a, b per physician G-749 7/24/97 reb

Certificate of Death

Reg. No.

| | | | | | | | |
|---|---|--|---|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Clara D. Harmon | | | 2. Date of Death
Month July Day 21 , Year 1997 | | 3. Time of Death
12:20 PM | |
| | 4a. Facility Name (If not institution, give street and number)
CHERRYWOOD NURSING & REHAB.
1111 Daniels Avenue | | | 4b. City, Town, or Location of Death
REISTERSTOWN
Baltimore | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-10-3563 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 14, 1909 |
| | 9. Birthplace (State or Foreign Country)
New York | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
1111 Daniels Avenue | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesperson | | 16b. Kind of Business/Industry
Dept. Store | | |
| | 17. Father's Name (First, Middle, Last)
Alfred Theis | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Siewerts | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Edna Wenck Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1111 Daniels Avenue Baltimore, MD 21207 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | Date
July 23 1997 | | 20c. Location - City or Town, State
Baltimore, Maryland |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Road
Lansdowne, Maryland 21227 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's Dementia
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
2 years | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year) | | | | | | |
| | 28b. Time of Injury
M | | | | | | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 28d. Describe how Injury occurred | | | | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| | 29b. Signature and title of certifier
 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
D27034 | | | | | | |
| | 29d. Date signed (Month, Day, Year)
July 22 1997 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Ira Copelan 15310 Old Court Road Randallstown MD 21133 | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
 | | | | | | |
| | 33. Date of Death (Month, Day, Year)
July 21, 1997 | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22294

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|----------------------------------|--|----------------|---|--|---|--|---|----|------------------------------|--|----------------------------------|--|--|----|--------------------------------|----------------|----------------------------------|--|--|----|---------------------------------|-----------------|----------------------------------|--|--|----|-----------------|-----------------|
| 1. Decedent's Name (First, Middle, Last)
Della Faye Krysiak | | | | 2. Date of Death
Month July Day 21 Year 1997 | | 3. Time of Death
10:18 PM | | | | | | | | | | | | | | | | | | | | | | | |
| 4a. Facility Name (If not institution, give street and number)
Genesis Eldercare Heritage Center | | | | 4b. City, Town, or Location of Death
Dundalk | | 4c. County of Death
Baltimore | | | | | | | | | | | | | | | | | | | | | | | |
| 5. Social Security Number
212-46-5471 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
51 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 4, 1946 | | | | | | | | | | | | | | | | | | | | | | | |
| 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10. Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
N/A | | | | | | | | | | | | | | | | | | | | | | | |
| 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
6409 Eastbourne Avenue | | 10f. Zip Code
21224 | | | | | | | | | | | | | | | | | | | | | | | |
| 10g. Citizen of What Country?
United States | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | | | | | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
10 Years | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress | | 16b. Kind of Business/Industry
Manufacturing | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
George Lowery | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ellen Louise Burke | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Diane L. Lewis/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8208 Diamond Point Road Baltimore, Maryland 21224 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 7/25/1997 | | 20c. Location - City or Town, State
Towson, Maryland | | 20d. Date
7/25/1997 | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Johnny L. Smith | | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Avenue Baltimore, Maryland 21222 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e.</td> <td>Myocardial Infarction</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Coronary Artery Disease</td> <td>2 years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Metabolic Encephalopathy</td> <td>9 months</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Dementia</td> <td>9 months</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. | Myocardial Infarction | | Due to (or as a consequence of): | | | b. | Coronary Artery Disease | 2 years | Due to (or as a consequence of): | | | c. | Metabolic Encephalopathy | 9 months | Due to (or as a consequence of): | | | d. | Dementia | 9 months |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. | Myocardial Infarction | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | Coronary Artery Disease | 2 years | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | Metabolic Encephalopathy | 9 months | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | Dementia | 9 months | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe Peripheral Vascular Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and Title of certifier
Harjit Singh M.D. | | 29c. License number
D14160 | | 29d. Date signed (Month, Day, Year)
07/22/97 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | 32. Registrar's Signature
John Davidson-Randall | | | | | | | | | | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

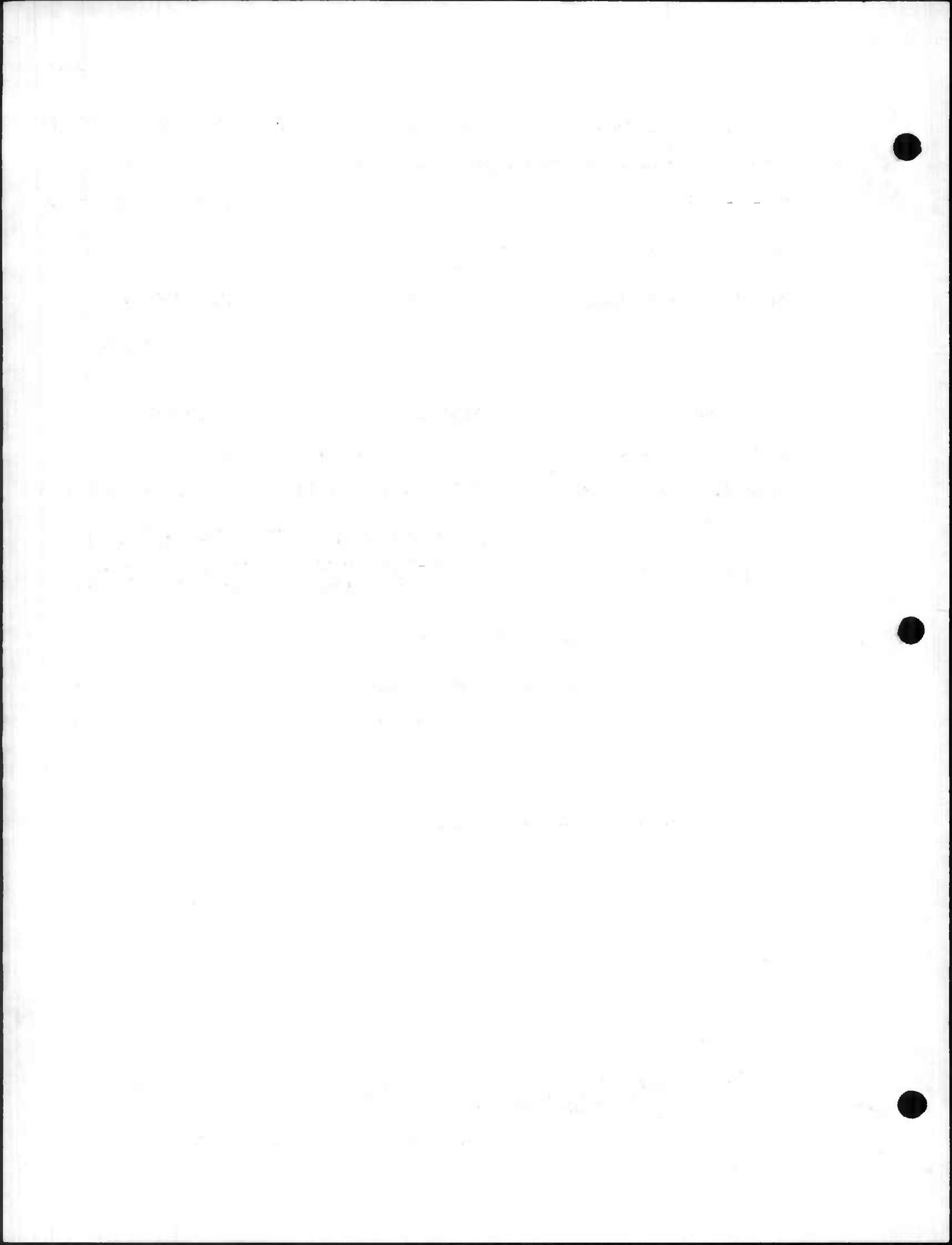
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

22295

| | | | | | |
|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Hazel F. Latimer</i> | | 2. Date of Death
Month <i>July</i> Day <i>21</i> Year <i>97</i> | | 3. Time of Death
<i>10²⁴A.</i> |
| | 4a. Facility Name (If not institution, give street and number)
<i>Liberty Medical Ctr.</i> | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>md</i> |
| Funeral
Director | 5. Social Security Number
<i>220-20-4166</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
<i>68</i> Yrs. | 8. Date of Birth (Month, Day, Year)
<i>5-9-1929</i> | 9. Birthplace (State or Foreign Country)
<i>Md</i> |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Md</i> | 10b. County
<i>NA</i> | 10c. City, Town or Location
<i>Baltimore</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
<i>1646 N. Bentalou Street</i> | | 10f. Zip Code
<i>21216</i> | | 10g. Citizen of What Country?
<i>U.S.A</i> |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th grade</i> College (1-4or 5+) <i>NA</i> | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Nursing Assistance</i> | | 16b. Kind of Business/Industry
<i>Hospital</i> | | |
| | 17. Father's Name (First, Middle, Last)
<i>John Johnson</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Rosie Edison</i> | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>To Ann Pope - Daughter</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4417 Manorview Road Baltimore, MD 21229</i> | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Arbutus Mem Park</i> | | 20c. Location - City or Town, State
<i>7-25-97 Arbutus, Md</i> |
| Physician
/Medical
Examiner | 21. Signature of Funeral Service Licensee
<i>Gabrielle Court</i> | | 22. Name and Address of Facility
<i>WM. C. MARCH FH.-4300 WABASH A VENUE</i> | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
e. <i>CONGESTIVE HEART FAILURE</i>
Due to (or as a consequence of):
b. <i>HYPERTENSION</i>
Due to (or as a consequence of):
c. <i>VALVULAR HEART DISEASE</i>
Due to (or as a consequence of):
d. | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Chronic Atrial Fibrillation</i> | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residencia <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| State Registrar | 29b. Signature and title of certifier
<i>MB Brochington MD</i> | | 29c. License number
<i>D32904</i> | | 29d. Date signed (Month, Day, Year)
<i>7-21-97</i> |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>4510 Liberty Heights Baltimore, Md 21207</i> | | | | |
| 31. Date filed (Month, Day, Year)
<i>JUL 24 1997</i> | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE A LINK

2. Date of Death

Month
JulyDay
18Year
1997

3. Time of Death

7:00AM

4a. Facility Name (If not institution, give street and number)

1217 Francis Ave.

4b. City, Town, or Location of Death

Arbutus

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

220-05-7420

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Nov 15, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1217 Francis Ave.

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1941-1944

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry
Refrigeration/
Air Conditioning

17. Father's Name (First, Middle, Last)

Christian Link

18. Mother's Name (First, Middle, Maiden Surname)

Florence Hausman Link

19a. Informant's Name/Relationship (Type, Print)

Joe Link Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2608 Thornbrook Road Ellicott City, Md 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Park

Date

July 21 1997

20c. Location - City or Town, State

Dorsey Maryland

21. Signature of Funeral Service Licensee

Paul Hagan

22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Road
Arbutus, Maryland 21227

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CARDIAC DYSRHYTHMIA

Due to (or as a consequence of):

Ten minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ATRIAL FIBRILLATION

Due to (or as a consequence of):

Five years

c. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Twenty-five years

d. CORONARY ARTERY DISEASE

Thirty years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSON'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jonathan Safren MD
STAFF CARDIOLOGIST

29c. License number

MARYLAND D41711

29d. Date signed (Month, Day, Year)

JULY 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN SAFREN MD 3449 WILKENS AVENUE SUITE 300 BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22297

| | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Francis Gregory Marrow | | | | 2. Date of Death
Month Day Year
JULY 20 1997 | | 3. Time of Death
11:30 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
3508 MARIGOLD DRIVE | | | | 4b. City, Town, or Location of Death
MONROVIA | | 4c. County of Death
FREDERICK | | |
| Funeral
Director | 5. Social Security Number
213 56 4491 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
46 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
SEPT. 15, 1950 | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD. | | 10b. County
FREDERICK | | 10c. City, Town or Location
MONROVIA | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
3508 MARIGOLD DRIVE | | | | 10f. Zip Code
21770 | | 10g. Citizen of What Country?
UNITED STATES | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Years 1970-1974 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PLUMBER | | 16b. Kind of Business/Industry
PLUMBING | | | |
| 17. Father's Name (First, Middle, Last)
HARRY MARROW | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LOUISE HARDING | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MARGARET V. MARROW, WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3508 MARIGOLD DRIVE, MONROVIA, MD. 21770 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LAYTONSVILLE CEMETERY | | 20c. Location - City or Town, State
7/24/97 LAYTONSVILLE, MD. | | | | |
| 21. Signature of Funeral Service Licensee
Muriel H. Barber | | | | 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME
P.O. BOX 5038, LAYTONSVILLE, MD. 20882 | | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. metastatic Colon Cancer
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
Two Years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
033686 | | 29d. Date signed (Month, Day, Year)
JULY 21, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Kenneth Miller, MD 18111 Prince Philip A. Okoy, MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

FRANCIS GREGORY MARROW

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

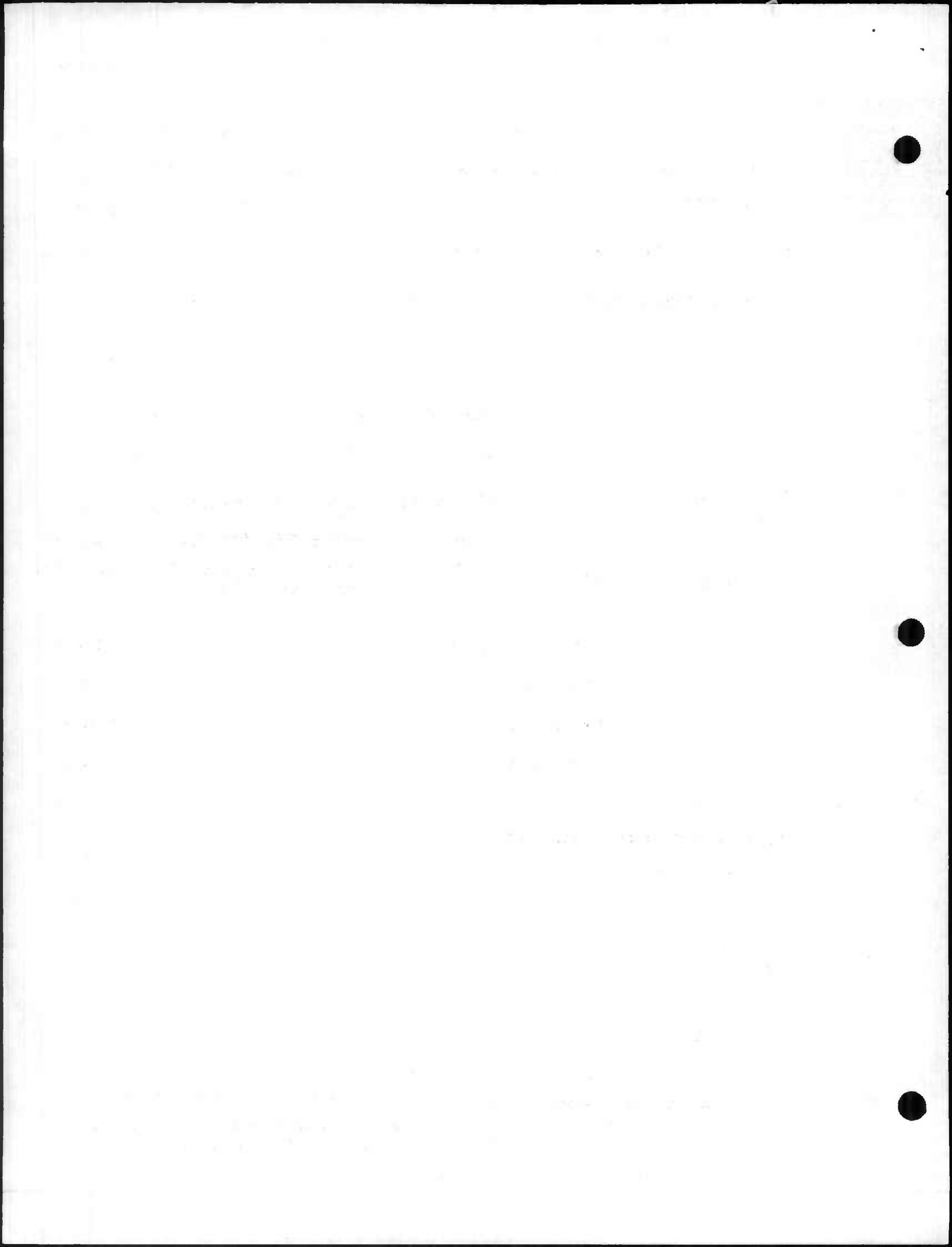
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22298

| | | | | | |
|---|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marion Mazan | | 2. Date of Death
Month July Day 17 Year 1997 | | 3. Time of Death
5:50 pm |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Bayview Medical Center | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
214-14-3233 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months 0 Days 0 | If Under 24 Hrs.
Hours 0 Min. 0 |
| | 8. Date of Birth (Month, Day, Year)
9/7/20 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
Baltimore |
| | 10c. City, Town or Location
Dundalk | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
3417 Cornwall Road | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
White | | 15. Decedent's Education (Specify only highest grade completed)
12th
Elementary/Secondary (0-12) College (1-4 or 5+) | | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Assembly Line | | 16b. Kind of Business/Industry
Automotive | | |
| | 17. Father's Name (First, Middle, Last)
Karol Mazan | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances Kutz | | |
| | 19e. Informant's Name/Relationship (Type, Print)
Skip Mazan/Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1025 Collins Ave. Sykesville, MD 21784 | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John the Baptist | | 20c. Location - City or Town, State
7/21/97 New Freedom, PA |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, MD 21222 | | |
| Physician
/Medical
Examiner | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) | | | | |
| | e. Respiratory Failure
Due to (or as a consequence of): | | | | 2 hours |
| | b. Brain Anoxia
Due to (or as a consequence of): | | | | 4 days |
| | c. Cardiac Arrest
Due to (or as a consequence of): | | | | 4 days |
| | d. Liver Hemorrhage
Due to (or as a consequence of): | | | | 4 days |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, atrial fibrillation,
ischemic colitis | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
July 18, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Christine D. Bussey, MD | | Johns Hopkins Bayview Medical Center
4940 Eastern Ave, Baltimore, MD 21224 | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | 32. Registrar's Signature
 | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22299

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|-----------------------------------|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Claracy Juanita Muldrow | | | | 2. Date of Death
Month Day Year
July 20 1997 | | | | 3. Time of Death
1020 | |
| | 4a. Facility Name (If not institution, give street and number)
Deaton University of Maryland Medicine | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
215-28-5462 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
02-06-23 | | 9. Birthplace (State or Foreign Country)
SC | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
2904 E. Federal Street | | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12th Grade B.S. Degree | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
in home | | |
| | 17. Father's Name (First, Middle, Last)
Sam Cousar | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Queen Coker | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Joyce Brown | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2904 E. Federal Street Baltimore, Maryland 21213 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | Date
07-25-97 | | 20c. Location - City or Town, State
Baltimore, Md. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C. MARCH FH 1101 E. North Avenue | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Sepsis Due to (or as a consequence of):
b. Infected wound Due to (or as a consequence of):
c. primary hyperparathyroidism Due to (or as a consequence of):
d. Congestive heart failure | | | | | | | | | |
| | Approximate Interval Between Onset and Death
1 week
2 weeks
? yrs.
1 yr. | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Multi-infarct dementia | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | 28d. Describe how Injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D34974 | | | | 29d. Date signed (Month, Day, Year)
7-21-97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
CHARU MEHTA, MD 5865 Robert Oliver Pl. #121, Columbia, MD 21045 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The use of this certificate is required for the death certificate to be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delivered for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

7

State
Registrar

WRC
97-3987-005
CYNTHIA J.
McGEEHAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22300

Items: 23a part I, 27, 28a-f per MEO G-750 8/6/97 dh Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cynthia J. McGeehan

2. Date of Death

Month Day Year
JULY 17, 1997

3. Time of Death

4:05 PM.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2200 WHITCOMB CIR.

4b. City, Town, or Location of Death

PARKVILLE

4c. County of Death

Baltimore

5. Social Security Number

217-80-6672

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 20, 1959

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

304 White Plains Court

10f. Zip Code

21146

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Computer Analyst

16b. Kind of Business/Industry

Drug Mfg.

17. Father's Name (First, Middle, Last)

Richard T. McGeehan

18. Mother's Name (First, Middle, Maiden Surname)

Joan E. Kassakatis McGeehan

19a. Informant's Name/Relationship (Type, Print)

Joan E. McGeehan Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

304 White Plains Court Severna Park, Md. 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Cemetery

Date

July 22, 1997

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc.
1328 Sulphur Spring Road
Baltimore, Maryland 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final
disease or condition
resulting in death)

a. BARBITURATE AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy
performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical
examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury
(Month, Day, Year)

found: 7/17/97

28b. Time of Injury

found: 1:03 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found: residence

28d. Describe how injury occurred

subject used drugs and alcohol

28f. Location (Street and Number or Rural Route Number, City or Town, State)
2200 Whitcomb Circle, Parkville, Maryland

29a. Certifier
(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Yannis N. Kousou 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22301

RITA MADERA

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---------------------------------|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Rita Madera | | | | 2. Date of Death
Month Day Year
JULY 18 1997 | | 3. Time of Death
9:40 AM | |
| | 4a. Facility Name (If not institution, give street and number)
SHOCK TRAUMA CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
Baltimore City | |
| Funeral
Director | 5. Social Security Number
217-16-6725 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 23, 1926 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Usual Residence of Decedent
10a. State
Maryland | | 10b. County
Baltimore City | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2611 Washington Blvd. | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Assembly Worker | | 16b. Kind of Business/Industry
Glass Company | | | |
| | 17. Father's Name (First, Middle, Last)
Howard Hartman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma Romm | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Helen Clark / Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2611 Washington Blvd. Baltimore, Md 21230 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | Date
July 22, 1997 | | 20c. Location - City or Town, State
Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home
421 Crain Hwy. S.E. Glen Burnie, MD 21061 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. stab wound of chest
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
7/18/97 | | 28b. Time of Injury
8430 M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred
self inflicted stab wound | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
home | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2611 Washington Blvd Baltimore, Md | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
JULY 19, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dennis J. Chute, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | | | | | |
| 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22302

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MORRIS O. NORRIS | | | | 2. Date of Death
Month July Day 21 Year 1997 | | 3. Time of Death
09:40 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Liberty Medical Center BALTIMORE, MD 21215. BALTIMORE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
220 18 6291A | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 16, 1906 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
4502 FAIRVIEW ROAD | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S. OF A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH College (1-4 or 5+) UNKNOWN | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
THEATRE MANAGER | | 16b. Kind of Business/Industry
THEATRE | | 17. Father's Name (First, Middle, Last)
MORRIS WAYMAN NORRIS | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
SUSAN WASHINGTON NORRIS | | 19a. Informant's Name/Relationship (Type, Print)
DORIS V. SMITH (DAUGHTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4502 FAIRVIEW ROAD BALTIMORE, MD. 21216 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. THOMAS CEMETERY | | 20c. Location - City or Town, State
BALTO. CO. | | 21. Signature of Funeral Service Licensee
<i>Lewis T. Gwynn</i> | | 22. Name and Address of Facility
LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO., MD. | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. PULMONARY EDEMA
Due to (or as a consequence of):
b. PNEUMONIA
Due to (or as a consequence of):
c. Renal Failure
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
12 days
12 days
Months | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, Hypothyroidism.
status post pacer insertion
atherosclerotic vascular disease | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Kwang N. Kim MD | | |
| 29c. License number
D 17 031 | | 29d. Date signed (Month, Day, Year)
July 21, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
KWANG N. Kim, M.D. 2600 Liberty Height. BALTIMORE, MD. 21215 | | 31. Data filed (Month, Day, Year)
JUL 24 1997 | | |
| 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

THE UNIVERSITY OF CHICAGO
DEPARTMENT OF CHEMISTRY
JAN 10 1964

TO THE DIRECTOR

FROM THE DEPARTMENT OF CHEMISTRY

RE: [illegible]
[illegible]
[illegible]

[illegible]
[illegible]
[illegible]

[illegible]
[illegible]
[illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22303**
Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Pauline Parr | | | | 2. Date of Death
Month 7 Day 18 Year 97 | | 3. Time of Death
11:30 pm | | |
| | 4a. Facility Name (If not Institution, give street and number)
IRVINGTON KNOLLS CARE CENTER | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
none | | |
| Funeral
Director | 5. Social Security Number
212-14-2851A | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
February 21, 1904 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
none | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
1701 W. Eutaw Street | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Afro American | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Collega (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Beautician | | 16b. Kind of Business/Industry
Self Employed | | | | |
| | 17. Father's Name (First, Middle, Last)
Joseph P. Parr | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Agnes Mary Breiscoe | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mary Weeder | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2823 Riggs Ave Baltimore, Md 21216 | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro | | 20c. Location - City or Town, State
7/19/97 Catonsville, Md | | | | |
| | 21. Signature of Funeral Service Licensed
Harry M. Cleelan | | | | 22. Name and Address of Facility
Wallace Funeral Service
3405 W. Franklin St Baltimore, Md 21229 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Cerebro Vascular Accident -
Atherosclerosis
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia
Dementia | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
N/A
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year)
N/A | | 28b. Time of Injury
N/A M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
N/A | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
N/A | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
S. J. J. J. | | 29c. License number
D43725 | | 29d. Date signed (Month, Day, Year)
7/19/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | 32. Registrar's Signature
Julia Anderson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29

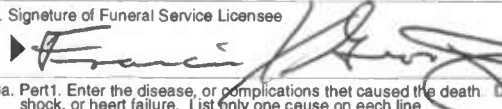
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

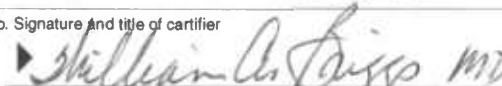

Certificate of Death

Reg. No.

97 22304

| | | | | | |
|-------------------------------------|---|---|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Carl Ridley | | 2. Date of Death
Month July Day 19 Year 97 | | 3. Time of Death
12:40pm |
| | 4a. Facility Name (If not institution, give street and number)
3150 Elmora Avenue | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA |
| Funeral
Director | 5. Social Security Number
217-26-4605 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F
XX | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
11-24-31 | | 9. Birthplace (State or Foreign Country)
Md. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
Md. | 10b. County
NA | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
3150 Elmora Avenue | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th Grade
College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Pipefitter | | 16b. Kind of Business/Industry
Bethlehem Steel Co. |
| | 17. Father's Name (First, Middle, Last)
Carl Lee Ridley | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Henry | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Randy Nicholson | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5722 Denwood Avenue Baltimore, Maryland 21206 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Calvary Cemetery | | 20c. Location - City or Town, State
07-25-97 Anne Arundel Co Md. |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. CARDIOMYOPATHY
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
YRS
YRS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSIVE AND ARTERIOSCLEROTIC
CARDIOVASCULAR DISEASES, CHRONIC
RENAL FAILURE | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year)
M
28b. Time of Injury
1 Yes <input type="checkbox"/> No
28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
D13611 | | 29d. Date signed (Month, Day, Year)
JULY 22, 1997 |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
William A. Briggs, MD, Ross 958, 720 Rutland Ave, Baltimore, MD 21205 | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUL 24 1997 | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22305

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Margaret Rusnak

2. Date of Death

Month
July

Day

17

3. Time of Death

Year

1997

12:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

187-01-0123

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 25 1916

9. Birthplace (State or Foreign Country)

Penn

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1001 Carroll Pkwy #304

10f. Zip Code

21701

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Hugh O'Donnell

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Mary Carrigan

19a. Informant's Name/Relationship (Type, Print)

Kevin E Rusnak

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1708 Maple Hill Place Alex. VA 22302

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Comfort Cemetery

Date

7/21/97

20c. Location - City or Town, State

Alex. VA

21. Signature of Funeral Service Licensee

Donald N. McDonald

22. Name and Address of Facility

Everly-Wheatley Funeral Home

1500 W Braddock Rd. Alex. VA 22302

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Mitral Regurgitation

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

~24 hrs.

~10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

a. Atrial Fibrillation

b. Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cham E. Decker MD

29c. License number

030496

29d. Date signed (Month, Day, Year)

7/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

300 W. 9th St; Frederick Md 21701

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Health and Vital Records Division: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#8 PER F.H. FLM#G749 7/23/97 J.A.

Certificate of Death

Reg. No.

97 22306

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
NETTIE REITER | | | | 2. Date of Death
Month JULY Day 18 Year 1997 | | 3. Time of Death
2 AM | | | |
| 4a. Facility Name (If not institution, give street and number)
MILFORD MANOR NURSING HOME | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | | | |
| 5. Social Security Number
071-20-6184 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV. 18, 1906 | | | |
| 9. Usual Residence of Decedent | | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
4204 OLD MILFORD MILL RD. | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | | | | |
| 17. Father's Name (First, Middle, Last)
LOUIS GOLDBIRSCH | | | | 18. Mother's Name (First, Middle, Maiden Surname)
TILLIE SANDBERG | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MRS. ANITA SCHULMAN (DAUG.) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9418 GROFFS MILL DR. OWINGS MILLS, MD 21117 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH DAVID (SONS OF JUDAH) | | 20c. Date
7/20/97 | | 20d. Location - City or Town, State
ELMONT, LI, NY | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic lung cancer
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
1 year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D37573 | | 29d. Date signed (Month, Day, Year)
July 18, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Jeff Zibell MD 7220 Park Heights Ave Baltimore MD 21206 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 23 1997 | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

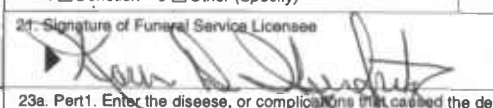
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


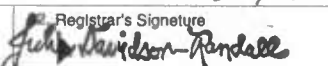
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22307

| | | | | | | | | | | |
|---|---|---|---|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Charles Allen Spicer | | | 2. Date of Death
Month Day Year
JULY 19 1997 | | 3. Time of Death
10:50 am | | | | |
| | 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | | | | |
| Funeral
Director | 5. Social Security Number
213-14-2185 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
92 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Jan. 13, 1905 | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Parkton | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
2834 Tracey's Store Rd. | | | | 10f. Zip Code
21120 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | 16. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Carpenter | | | 16b. Kind of Business/Industry
City Government | | | | |
| | 17. Father's Name (First, Middle, Last)
William J. Spicer | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sara Simpson | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Robert C. Spicer/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2834 Tracey's Store Rd., Parkton, MD 21120 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wiseburg Cemetery | | Date
July 21, 1997 | | 20c. Location - City or Town, State
White Hall, MD | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
J.J. Hartenstein Mortuary, Inc.
24 Second St., New Freedom, PA 17349 | | | | | |
| | 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Respiratory Failure
Due to (or as a consequence of):
b. Congestive Heart Failure years
c. Renal Failure years
d. Anemia years
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29b. Signature and title of certifier

Patricia Tom MD | | 29c. License number
037898 | | 29d. Date signed (Month, Day, Year)
7/19/97 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Patricia Tom MD 2205 York Road Timonium, MD 21093 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | Registrar's Signature
 | | | | | | | | |

Spicer Charles A
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22308

Items: 23 part I, 27 per MEO G-749 7/24/97 reb

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BRIANNA STALLINGS | | 2. Date of Death
Month Day Year
APRIL 21, 1997 | | 3. Time of Death
1445PM |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NT / A |
| Funeral
Director | 5. Social Security Number
214-49-4365 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
Yrs. 3 Months 3 Days | 8. Date of Birth (Month, Day, Year)
Jan. 18, 1997 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Lansdowne | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
3163 Kessler Road | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Infant | | 16b. Kind of Business/Industry
None |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
John Wesley Stallings | | 18. Mother's Name (First, Middle, Maiden Surname)
Amy Michele Green | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Amy Michelle Green/Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3163 Kessler Rd. Baltimore Maryland 21227 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery | | 20c. Location - City or Town, State
Baltimore Maryland |
| | 21. Signature of Funeral Service Licensee
Paul Hagan | | 22. Name and Address of Facility
AMBROSE FUNERAL HOME
2719 HAMMONDS FERRY RD.
21227 | | Approximate Interval Between Onset and Death |
| Physician
/Medical
Examiner | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

SUDDEN INFANT DEATH SYNDROME | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) | | | | |
| | 28b. Time of Injury
M | | | | |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 28d. Describe how Injury occurred | | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
Wayne M. Hagan | | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
O.C.M.E | | | | |
| | 29d. Date signed (Month, Day, Year)
APRIL 22, 1997 | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wayne M. Hagan, 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | |
| State Registrar | 32. Registrar's Signature
John Davidson-Randall | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#15,16a,b 24A PER PHYN\$ FLMG749 7/24/97 Certificate of Death

Reg. No.

22309

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | |
|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Danielle Nicole Schoonover | | 2. Date of Death
Month June Day 19 Year 1997 | | 3. Time of Death
0745 | | |
| 4a. Facility Name (If not institution, give street and number)
Shady Grove Adventist Hospital | | 4b. City, Town, or Location of Death
Rockville, MD | | 4c. County of Death
Montgomery | | |
| 5. Social Security Number
217-49-6267 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 54 | | |
| 8. Date of Birth (Month, Day, Year)
April 25, 1997 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | |
| Usual Residence of Decedent | | | | | | |
| 10a. State
Md. | | 10b. County
Frederick | | 10c. City, Town or Location
Frederick | | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 10e. Street and Number
578 Boysenberry Lane | | 10f. Zip Code
21702 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
INFANT | | 16b. Kind of Business/Industry
NONE | | |
| 17. Father's Name (First, Middle, Last)
Carey R. Schoonover | | 18. Mother's Name (First, Middle, Maiden Surname)
Theresa Addington | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Carey R. Schoonover (Father) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
578 Boysenberry Lane, Frederick, Md. 21702 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory | | 20c. Location - City or Town, State
6/20 Smithsburg, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Donald B. Thompson Funeral Home
31 E. Main St., Middletown, Md. 21769 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Septic Shock
Due to (or as a consequence of):
b. Necrotizing Enterocolitis
Due to (or as a consequence of):
c. Acute Renal Failure
Due to (or as a consequence of):
d. Colonic Perforation

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death
5 Days
5 Days
72 hours
72 hours |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Extreme Prematurity | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
June 19, 1997 | | | | | | |
| 28b. Time of Injury
M | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 28d. Describe how injury occurred | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. Signature and title of certifier
Terri DiFazio | | | | | | |
| 29c. License number
50453 | | | | | | |
| 29d. Date signed (Month, Day, Year)
June 19, 1997 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shady Grove Adventist Hospital
Terri DiFazio, MD-PEDIATRIC DEPT. 9901 Medical Ctr. Dr., ROCKVILLE, MD 20850 | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 30 1997 | | | | | | |
| 32. Registrar's Signature
R. R. R. | | | | | | |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

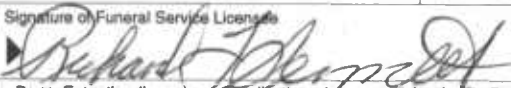
State of Maryland / Department of Health and Mental Hygiene

ITEM: 3,4a per DR. G-750 8-7-97
Item 3 Per Phy Item 7,8,9, Per FH Film G749 7-25-97

Certificate of Death

Reg. No.

97 22310


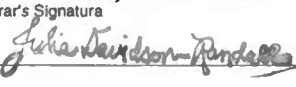
| | | | | | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RAYMOND FRANCIS SWITZER | | | | 2. Date of Death
Month JULY Day 9 Year 1997 | | | | 3. Time of Death
1:15am
Unknown | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
319 SOUTH DEAN STREET 319 SOUTH DREW STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
CITY | | | | | |
| Funeral
Director | 5. Social Security Number
483-07-7138 | | 6. Sex
XX M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
12/29/19 | | 9. Birthplace (State or Foreign Country)
Iowa | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
CITY | | 10c. City, Town or Location
BALTIMORE CITY | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number
319 SOUTH DREW STREET | | | | 10f. Zip Code
21224 | | | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CIVIL ENGINEER | | | | 16b. Kind of Buainess/Industry
CROWN CORK & SEAL | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
CARL SWITZER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARY UNKNOWN | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
DOROTHY M. FOEHRKOLB | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
319 SOUTH DREW STREET BALTIMORE, MD 21224 | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OAK LAWN CEMETERY | | | | Data
JULY 12, 1997 | | 20c. Location - City or Town, State
BALTIMORE, MD | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
CHARLES S. ZEILER & SON, INC.
6224 EASTERN AVENUE BALTIMORE, MD 21224 | | | | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
b. VENTRICULAR SEPTAL DEFECT
Due to (or as a consequence of):
c. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death

3 YRS

10 YRS

10 YRS | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
AORTIC STENOSIS | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D24740 | | | | 29d. Date signed (Month, Day, Year)
JULY 10, 1997 | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND 21287 THOMAS A. TRAILL, M.D. | | | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | 32. Registrar's Signature
 | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 21, 22 per FH G-750 8/22/97 dh

Item 16ab, 17, 18, 20bc Per FH Film G750 8-21-97 rjs

Certificate of Death

Reg. No.

97 22311

| | | | | | | | | |
|--|---|--|---|---|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Carr Smith | | | | 2. Date of Death
Month July Day 11 Year 1997 | | 3. Time of Death
7:10 AM | |
| | 4a. Facility Name (If not institution, give street and number)
St. Agnes Hosp. 900 Caton Ave | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
205-22-0473 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
June 13, 1930 | 9. Birthplace (State or Foreign Country)
Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Baltimore City | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
22 S. Athol Avenue | | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
unknown Car Dealer | | 16b. Kind of Business/Industry
A.D. Anderson
unknown | | | |
| | 17. Father's Name (First, Middle, Last)
unknown RUFF SMITH | | | | 18. Mother's Name (First, Middle, Maiden Surname)
unknown ANNA CARR | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Christine Smith/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
834 N. Carey Street, Baltimore, Maryland 21229 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest | | Data
8/1/97 | | 20c. Location - City or Town, State
Owings Mills, MD | |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade | | | | 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> a. Adenocarcinoma of the lung
 Due to (or as a consequence of):
 b. Gastrointestinal bleeding
 Due to (or as a consequence of):
 c. Bilateral pneumonia
 Due to (or as a consequence of):
 d. </div> <div style="width: 35%;"> Years
 1 week
 1 week </div> </div> | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated. | | 29b. Signature and title of certifier
Radu S. Iancovici MD | | 29c. License number
TO10874 | | 29d. Date signed (Month, Day, Year)
7/11/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Radu S. Iancovici St. Agnes Hosp 900 Caton Ave Balto MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | 32. Registrar's Signature
Juba Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: SMITH CARR

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA MARYLAND SMITH

2. Date of Death

Month

Day

Year

3. Time of Death

JULY

22

1997

1:40

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE ANNE ARUNDEL

4c. County of Death

5. Social Security Number

217-26-5223

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JAN 29 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

PASADENA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

101 HOPELAND AVE.

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOUSEHOLD

17. Father's Name (First, Middle, Last)

DEVEREAUX

VENABLE

BELL

18. Mother's Name (First, Middle, Maiden Surname)

MARIA

ELIZABETH

PAGE

19a. Informant's Name/Relationship (Type, Print)

DOLORES BELL sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 HOPELAND AVE. PASADENA, MARYLAND 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GLEN HAVEN CEMETERY

Date

JUL. 25, 97 GLEN BURNIE MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Henry L. Stallings Jr.

22. Name and Address of Facility

STALLINGS FUNERAL HOME P.A.
3111 MOUNTAIN ROAD PASADENA, MARYLAND 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial infarction

Due to (or as a consequence of):

b. Chronic heart disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Days

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John P. Anderson - M.D.

29c. License number

J40525

29d. Date signed (Month, Day, Year)

7/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John P. Anderson - M.D. North Arundel Hospital

31. Date filed (Month, Day, Year)

JUL 24 1997

John P. Anderson - M.D.

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22313

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Frances Catherine Sauer | | | | 2. Date of Death
Month July Day 21 Year 1997 | | 3. Time of Death
3:15 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore County | | |
| Funeral
Director | 5. Social Security Number
217-16-4878 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
72 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 13, 1925 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
6605 Marietta Avenue | | | | 10f. Zip Code
21214 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 6/14/45-6/21/47 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Bookkeeper | | 16b. Kind of Business/Industry
Shipping Company | | |
| | 17. Father's Name (First, Middle, Last)
Charles John Frank | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances M. Nueslein | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Teresa Ann Lotito/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6605 Marietta Avenue, Baltimore, Maryland 21214 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland National Memorial Park | | 20c. Location - City or Town, State
Laurel, Maryland | | 20d. Date
7/25/97 | | |
| | 21. Signature of Funeral Service Licensee
<i>Guarita R Thomas</i> | | | | 22. Name and Address of Facility
John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Congestive Heart Failure
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Angina | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>John C. Miller MD</i> | | | | 29c. License number
032543 | | 29d. Date signed (Month, Day, Year)
7/23/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MANUE STROMBERG 7505 OSCAR Dr. Towson MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

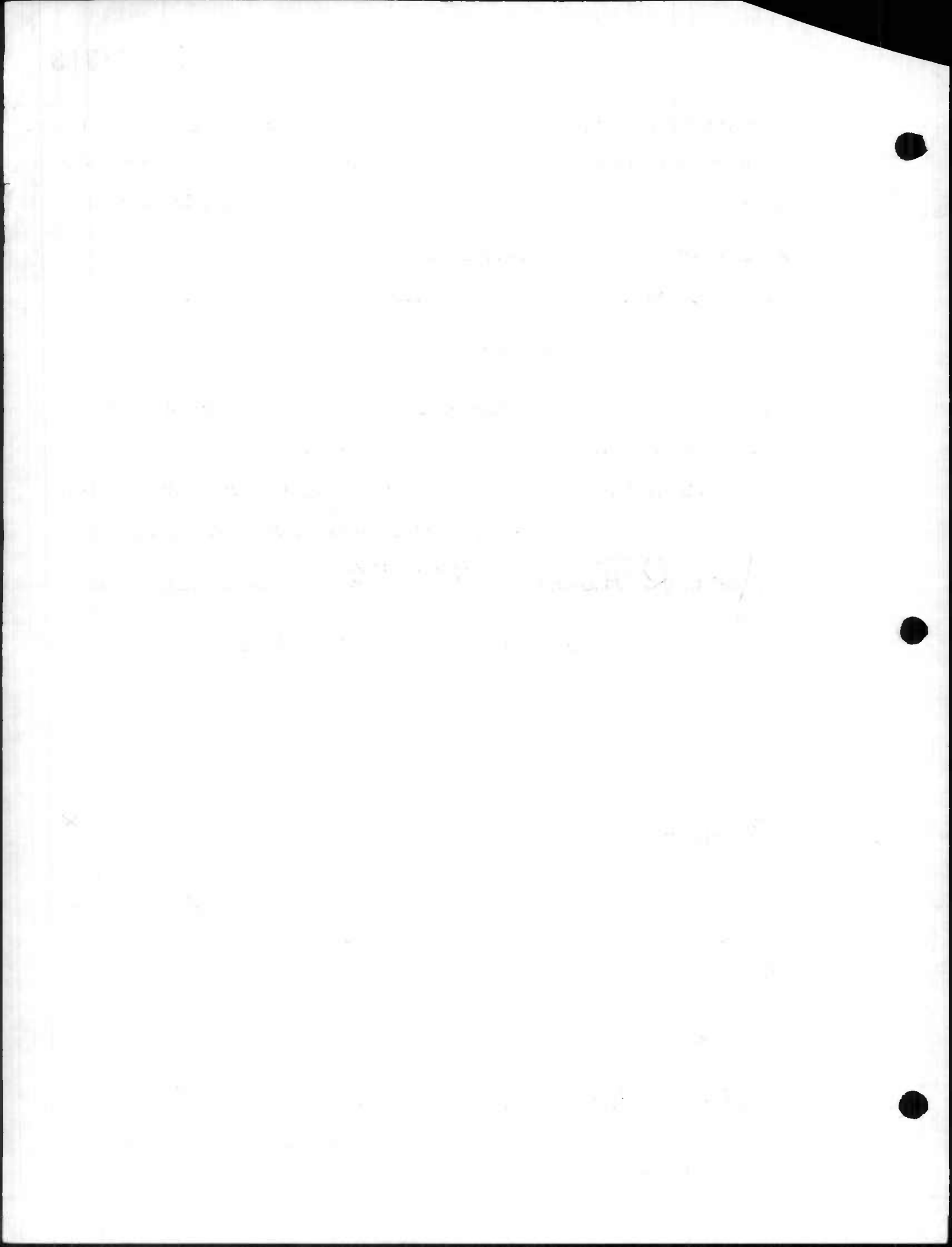
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Item 1 Per PHY Film G749 7-25-97 rja
Item 8 per FH G-750 8/1/97 dh

97 22314

| | | | | | |
|-------------------------------------|---|--|---|--------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
TIMMERMANN | | 2. Date of Death
Month JULY Day 13 , Year 1997 | | 3. Time of Death
4:30 PM |
| | 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore |
| Funeral
Director | 5. Social Security Number
212-01-2197 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
June 14, 1911 | | 9. Birthplace (State or Foreign Country)
Baltimore, Md. | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore |
| | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
8704 Edgefield Road | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th. College (1-4 or 5+) 4 yrs. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Draftsman | | 16b. Kind of Business/Industry
Fenton & Lichtig |
| | 17. Father's Name (First, Middle, Last)
Charles Henry Timmermann, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna May Colburn | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Agnes E. Timmermann (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8704 Edgefield Road Baltimore, Md. 21234 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | 20c. Location - City or Town, State
7/16/97 Baltimore, Maryland |
| | 21. Signature of Funeral Service Licensee
E. F. Lassahn | | 22. Name and Address of Facility
E. F. Lassahn Funeral Home
11750 Belair Road Kingsville, Md. 21087 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
ASPIRATION PNEUMONIA
a. Due to (or as a consequence of):
ANEMIA
b. Due to (or as a consequence of):
ZENKER'S DIVERTICULUM
c. Due to (or as a consequence of):
DIVERTICULOSIS
d. | | | | Approximate Interval Between Onset and Death
DAYS
YEARS
YEARS
YEARS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ACUTE PAROTITIS | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
Ceballos, M.D. | | 29c. License number
D 25886 | | 29d. Date signed (Month, Day, Year)
July 13 - 1997 |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
LILIA CEBALLOS, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUL 24 1997 | | 32. Registrar's Signature
Julia Davidson-Randall | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22315

| | | | | | | | | |
|--|---|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Flora Kate TULL | | | | 2. Date of Death
Month Day Year
July 22nd 1997 | | 3. Time of Death
9:45 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Liberty Medical Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
218-26-3470 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
1-18-1926 | |
| | 9. Birthplace (State or Foreign Country)
N.C. | | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
3329 Gwynnsfalls Parkway | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
House w.f.c | | 16b. Kind of Business/Industry
Home | | 17. Father's Name (First, Middle, Last)
John Henry Williams, Sr | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Ruth Artis | | 19a. Informant's Name/Relationship (Type, Print)
Paula Tull Washington Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3329 Gwynnsfalls Parkway Baltimore, MD 21216 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville Veteran Cem 7-25-97 | | 20c. Location - City or Town, State
Crownsville, MD | | 21. Signature of Funeral Service Licensee
Gabrielle Cook | | 22. Name and Address of Facility
March F.H. West 4300 Wabash Avenue Baltimore, MD 21215 | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Endstage Renal Disease
Due to (or as a consequence of):
b. Urosepsis
Due to (or as a consequence of):
c. Hypotension
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
1 WK.
1 WK | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
House officer | | |
| 29c. License number
038993 | | 29d. Date signed (Month, Day, Year)
July 22nd 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Laura Clevor 2600 Liberty Heights Baltimore MD 21215 | | 31. Date filed (Month, Day, Year)
JUL 24 1997 | | |
| 32. Registrar's Signature
Julia Davidson-Randall | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22316

Reg. No.

| | | | | | | | | |
|---|---|---------------------------------------|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<div style="font-size: 1.5em; font-family: cursive;">Leroy Tuttle</div> | | | | 2. Date of Death
Month Day Year
<div style="font-size: 1.2em; font-family: cursive;">July 22 1997</div> | | 3. Time of Death
<div style="font-size: 1.2em; font-family: cursive;">7:15 pm</div> | |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Bayview Geriatric Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
471-05-9739 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 21, 1908 | |
| | 9. Birthplace (State or Foreign Country)
Wisconsin | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
3218 Tyndale Avenue | | 10f. Zip Code
21214 | |
| | 10g. Citizen of What Country?
United States | | | | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Engineer | | | | 16b. Kind of Business/Industry
U.S. Government | | | |
| | 17. Father's Name (First, Middle, Last)
Allen P. Tuttle | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sophie Brandt | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Norbert Luken / Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Randell Avenue Perry Hall, MD 21128 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cemetery | | 20c. Date
7/26/97 | | 20d. Location - City or Town, State
Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee
<div style="font-size: 1.2em; font-family: cursive;">Timothy S. Harman</div> | | | | 22. Name and Address of Facility
Leonard J. Ruck, Inc. Funeral Home
5305 Harford Road Baltimore, MD 21214 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p style="font-size: 1.2em; font-family: cursive;">a. aspiration pneumonia</p> <p style="font-size: 1.2em; font-family: cursive;">b. metastatic prostate cancer</p> <p style="font-size: 1.2em; font-family: cursive;">c. Parkinsons disease</p> <p style="font-size: 1.2em; font-family: cursive;">d. vocal cord paralysis</p> </div> <div style="width: 25%;"> <p>Approximate Interval Between Onset and Death</p> <p style="font-size: 1.2em; font-family: cursive;">1 month</p> <p style="font-size: 1.2em; font-family: cursive;">1 year</p> <p style="font-size: 1.2em; font-family: cursive;">several years</p> <p style="font-size: 1.2em; font-family: cursive;">1 year</p> </div> </div> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<div style="font-size: 1.2em; font-family: cursive;"> ischemic cardiomyopathy
 atrial arrhythmia
 chronic anemia </div> | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 28f. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. Signature and title of certifier
<div style="font-size: 1.5em; font-family: cursive;">W.B. Greenough</div> | | | | 29c. License number
DO4383 | | 29d. Date signed (Month, Day, Year)
7/23/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W.B. Greenough MD 3 HGC BAIT MD 21224 | | | | | | | | |
| 31. Date filed (Month, Day Year)
JUL 24 1997 | | | | 32. Registrar's Signature
<div style="font-size: 1.2em; font-family: cursive;">Gina Davidson-Randall</div> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97-22317

| | | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Philip H. Turner | | | | 2. Date of Death
Month July Day 23, 1997 Year | | | | 3. Time of Death
12:30 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Woods | | | | 4b. City, Town, or Location of Death
Rosedale | | | | 4c. County of Death
Baltimore County | |
| Funeral
Director | 5. Social Security Number
212-09-6081 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 10, 1916 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | 10a. Street and Number
5908 Farmview Avenue | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | |
| To Be Completed by Funeral Director | 10e. State
Maryland | | 10b. County
Baltimore County | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1943-1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 Years | | 16. Kind of Business/Industry
Railroad | | 17. Father's Name (First, Middle, Last)
Algie Leroy Turner | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Unknown Schaefer | |
| | 19a. Informant's Name/Relationship (Type, Print)
Nicoletta P. Turner/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5908 Farmview Avenue, Baltimore, Maryland 21206 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cemetery | | Date
7/26/97 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
Guanta R. Thomas | | | | 22. Name and Address of Facility
John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Cor lung
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
2 yrs | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
MD | | | | 29c. License number
D18487 | | 29d. Date signed (Month, Day, Year)
7/23/97 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MYO THIAN 6830 HOSPITAL DRIVE, BALTO, MD 21237 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 24 1997 | | 32. Registrar's Signature
Julia Davidson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22318

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Geoffery WATTS

2. Date of Death

July 16 1997 3 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

318 Thomas Drive

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

5. Social Security Number

105-44-7584

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

8-31-52

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

318 Thomas Drive

10f. Zip Code

20707

10g. Citizen of What Country?

U.S.

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Producer

16b. Kind of Business/Industry

Music

17. Father's Name (First, Middle, Last)

Jack C WATTS

18. Mother's Name (First, Middle, Maiden Surname)

Shirley M Wright

19a. Informant's Name/Relationship (Type, Print)

Jacquelyn WATTS (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

56 Stokes Court Baton Rouge La 70808

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

7/18/97 Baltimore MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Lamont Thompson

22. Name and Address of Facility

E.L. Phillips
1721-27 N MONROE ST Balt MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Adenocarcinoma

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending Investigation
20 Accident 60 Could not be determined
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lamont Thompson MD

29c. License number

D50059

29d. Date signed (Month, Day, Year)

July 24, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Lawrence Gardner Johns Hopkins Oncology Center Baltimore MD 21287

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22319

ITEM# 24a PER PHYNS. FLM#G749 7/24/97 J.A.

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THOMAS A. WASHINGTON | | | | 2. Date of Death
Month JULY Day 11 Year 1997 | | 3. Time of Death
2:40AM | |
| | 4a. Facility Name (If not institution, give street and number)
SOUTHEAST MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death
CLAYTON | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
229-26-9673 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
Apr. 2, 1928 | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Fort Washington | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
2930 Tucker Road | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Heavy Equipment Operator | | 16b. Kind of Business/Industry
Construction | | | | |
| 17. Father's Name (First, Middle, Last)
Charlie Washington | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Eleanor Elizabeth Glascoe | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Eleanor Jameson Frye-daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RR1 Box 80A Madison, VA 22727 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Good Hope Baptist Church Cemetery | | 20c. Date
7/16/97 | | 20d. Location - City or Town, State
Norman, Virginia | | |
| 21. Signature of Funeral Service Licensee
Byron J. Flecker | | 22. Name and Address of Facility
Found Sons Funeral Home
850 Sperryville Pkwy, Culpeper, Va. 22701 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | 29c. License number
D-18545 | | 29d. Date signed (Month, Day, Year)
JULY 11, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Philip Wisorsky MD 700 Old Line Center Waldorf, Md. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | | | | | |
| 32. Registrar's Signature
[Signature] | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22320

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FLORENCE QUEENIE WILSON

2. Date of Death

Month JULY Day 22 Year 1997

3. Time of Death

5:35 PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-22-9506

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
February 2, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

Maryland Baltimore

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3116 Fairview Road

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

N/A

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Wife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Lorenzo Vessels

18. Mother's Name (First, Middle, Maiden Surname)

Quennie Rice

19a. Informant's Name/Relationship (Type, Print)

James G. Wilson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3116 Fairview Road, Baltimore, Maryland 21207

20e. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

entombment Arbutus Mem. Park

Date

July 25, 1997

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Carlton P. Douglass

22. Name and Address of Facility

Douglass Funeral Service
1701 McCulloch Street, Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. HEMORRHAGE OF AORTIC ANEURYSM REPAIR

Approximate Interval Between Onset and Death

5 DAYS

Due to (or as a consequence of):

b. AORTIC ANEURYSM GRAFT REPAIR

5 DAYS

Due to (or as a consequence of):

c. ABDOMINAL AORTIC ANEURYSM

YEARS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert J. Falconer

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

JULY 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT J. FALCONER UNION MEMORIAL HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Florence Queenie Wilson
Division of Vital Records, P.O. Box 68760,

Items: 23a part I, 27, 28a-f per MEO G-749 7/29/97 dh

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Percy S. Whitehead, Jr. | | | | 2. Date of Death
Month JULY Day 19 Year 1997 | | 3. Time of Death
1005 AM | |
| | 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL E.R. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
220-88-4881 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
32 Yrs. | | 8. Date of Birth (Month, Day, Year)
06-24-65 | |
| | 9. Birthplace (State or Foreign Country)
Md. | | 10a. State
Md. | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
2318 E. Fairmount Avenue | | 10f. Zip Code
21224 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) NA | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Groundskeeper | | | | 16b. Kind of Business/Industry
Chapel Asst. | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Percy Whitehead, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Scott | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mary L. Whitehead | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2318 E. Fairmount Avenue Baltimore, Md. 21224 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Western Star Cemetery 07-25-97 Catonsville, Md | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM C. March FH 1101 E. North Avenue | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ALCOHOL, COCAINE AND NARCOTIC INTOXICATION
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year)
7/19/97 found | | | |
| | 28b. Time of Injury
unknown | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred
subject ingested drugs and alcohol | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
2217 Orleans Street, Baltimore, Md. | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
O.C.M.E | | | | 29d. Date signed (Month, Day, Year)
JULY 20, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
 | | | | 33. Registrar's Name
Julia Davidson-Randall | | | |
| | 34. Registrar's Title
Registrar | | | | 35. Registrar's Address
111 Penn Street, Baltimore, Maryland 21201 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22322

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SANDRA Sue Walker | | | | 2. Date of Death
Month June Day 19 Year 1997 | | 3. Time of Death
unknown | |
| | 4a. Facility Name (If not institution, give street and number)
19348 Circle Gate Drive | | | | 4b. City, Town, or Location of Death
GERMANTOWN | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
237-98-5774 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
42 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 6, 1954 | |
| | 10e. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Germantown | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
19348 Circle Gate Drive | | 10f. Zip Code
20874 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | | |
| 17. Father's Name (First, Middle, Last)
Forrest Schumaker | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Christian | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Barry Louis Walker | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19348 Circle Gate Drive, Germantown Md. 20874 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cem. | | Date
6-25-97 | | 20c. Location - City or Town, State
Arlington, Virginia | | |
| 21. Signature of Funeral Service Licensae
Richard Decosta per V.R. | | | | 22. Name and Address of Facility
Affordable Funeral Services Dunn Loring, Va. 22027 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Liver Failure
Due to (or as a consequence of):
b. End Stage Liver Disease
Due to (or as a consequence of):
c. Liver TRANSPLANT
Due to (or as a consequence of):
d. Primary Sclerosing Cholangitis

Approximate Interval Between Onset and Death
3 mos
21 mos
6 yr | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice Care | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
DR. FRANK MOSES COL. MC | | | | 29c. Licensa number
TN 14214(3/3/98) | | 29d. Date signed (Month, Day, Year)
6/26/97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
FRANK MOSES, MD GASTROENTEROLOGY SVC, WRAMC, Washington, DC 20307 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 24 1997 | | | | 32. Registrar's Signature
Julia Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22323

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Manuel

2. Date of Death

Month Day Year
July 04 1997

3. Time of Death

0730

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

577-07-5933

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 5, 1914

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2204 Westview Ct.

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII
Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Benjamin Auerbach

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Kaplin

19a. Informant's Name/Relationship (Type, Print)

Rachel Auerbach/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10a - 10f

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Lebanon Cemetery

Date

7/6/97

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Homes 22046

472 N. Washington St. Falls Church, VA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Sepsis
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

one month

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease, Anemia of
renal failure, Atherosclerotic heart disease,
Encephalopathy, Peripheral Vascular Disease, Gangrene

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey A. Perlmutter MD

29c. License number

D47188

29d. Date signed (Month, Day, Year)

July 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jeffrey A. Perlmutter MD, 6240 Montrose Road, Rockville MD 20852

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22324

| | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DAVID FLAVIO ALCANTARA JR | | | | 2. Date of Death
Month 07 Day 02 Year 97 | | | | 3. Time of Death
0645 | |
| | 4a. Facility Name (If not Institution, give street and number)
Clinical Center National Institutes of Health Bethesda | | | | 4b. City, Town, or Location of Death
Montgomery | | | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
N/A | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
17 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 19, 1980 | | 9. Birthplace (State or Foreign Country)
Dominican Rep. | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
Washington, D.C. | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. State
none | | 10b. County
none | | 10f. Zip Code
20011 | | | | 10g. Citizen of What Country?
resident alien | | |
| 10e. Street and Number
1532 Varnum Street, N.W. | | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify:
Dominican Republic | | 14. Race - American Indian, Black, White, etc.
Specify:
hispanic | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
11 | | College (1-4 or 5+)
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
student | | 16b. Kind of Business/Industry
high school | | | | |
| 17. Father's Name (First, Middle, Last)
David Flavio Alcantra | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mercedes Sanchez | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mercedes Ross/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1532 Varnum St., N.W., Wash., DC 20011 | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Date
July 8, 97 | | 20c. Location - City or Town, State
Alexandria, Va. | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
DeVol Funeral Home
2222 Wisconsin Ave., N.W., Wash., DC 20007 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | |
| e. <u>CARDIORESPIRATORY Arrest</u>
Due to (or as a consequence of): | | | | | | | | | | |
| b. <u>Progressive metastatic Rhabdomyosarcoma</u>
Due to (or as a consequence of): | | | | | | | | | | 1 yr |
| c. <u>Metastatic Rhabdomyosarcoma</u>
Due to (or as a consequence of): | | | | | | | | | | 8 yr |
| d. _____ | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | | | | | | | |
| 29c. License number
NY 2101007 | | 29d. Date signed (Month, Day, Year)
July 2 1997 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ELIZABETH FOX, MD PEDIATRIC BRANCH NCI RM 13N240 Building 10 NIH 9000 Rockville Pike Bethesda MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 08 1997 | | 32. Registrar's Signature
 | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

2

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22325

RAY
ADAMS

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ray Steven Adams | | | | | | 2. Date of Death
Month JULY Day 4 Year 1997 | | 3. Time of Death
7:25 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
3111 HARMONY CHURCH ROAD | | | | | | 4b. City, Town, or Location of Death
Darlington | | 4c. County of Death
HARFORD COUNTY | |
| Funeral
Director | 5. Social Security Number
217-62-3459 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
43 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 27, 1954 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Aberdeen | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
57 Aberdeen Avenue | | | | 10f. Zip Code
21001 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates 1972-74 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | | 16b. Kind of Business/Industry
Construction | | |
| | 17. Father's Name (First, Middle, Last)
Ray Adams | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lorene Mullis | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Timothy Adams (Brother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 Anchor Ct., Perryville, MD 21903 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Antioch Baptist Cemetery | | Date
7/9/97 | | 20c. Location - City or Town, State
Sparta, North Carolina | | | |
| | 21. Signature of Funeral Service Licensee
Karen Amy Unglesbee | | | | 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Head injury
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| Physician
/Medical
Examiner | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROAD | | | | | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
7-4-97 | | 28b. Time of Injury
1042 M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Driver ejected from car | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Road | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
3111 Harmony Church Rd. | | | | | | | |
| State
Registrar | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
[Signature] | | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
JULY 5, 1997 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
AM DIXON
111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 7 1997 | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 977122326

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cristina Alexander

2. Date of Death

Month July

Day 11

Year 97

3. Time of Death 00:34

4a. Facility Name (If not institution, give street and number)

University of Maryland Shock Trauma Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-84-0001

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

21

8. Date of Birth (Month, Day, Year)

Jan 7 1976

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

Cecil

10c. City, Town or Location

Chesapeake City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

232 Biddle St.

10f. Zip Code

21915

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Kevin Bowe

18. Mother's Name (First, Middle, Maiden Surname)

Dawn Mann

19a. Informant's Name/Relationship (Type, Print)

Dawn Caleb, Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

232 Biddle St. Chesapeake City MD 21915

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Cemetery July 14 1997

Date

20c. Location - City or Town

Chesapeake City MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. T. Foard Funeral Home, PA
111 S Queen St. Rising Sun MD 21915

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEVERE INTRAABDOMINAL HEMORRHAGE

Due to (or as a consequence of):

STATUS POST MOTOR VEHICLE CRASH

Due to (or as a consequence of):

PELVIC / MULTIPLE BONEY FRACTURES

Due to (or as a consequence of):

SPLENIC RUPTURE, SEVERE LIVER INJURY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

07/10/97

28b. Time of injury

9:32 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Motor Vehicle Crash

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Basile Ave & Randall Rd, Chesapeake City MD

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William C. Chin, M.D.

29c. License number

046147

29d. Date signed (Month, Day, Year)

7/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sam Ibrahim, Shock Trauma Center

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

Johanna Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0026

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22327

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Emma B. Archer | | | | 2. Date of Death
Month July Day 06 Year 1997 | | 3. Time of Death
11:10am | | |
| | 4a. Facility Name (If not institution, give street and number)
Golden Age Guest Home | | | | 4b. City, Town, or Location of Death
Sykesville | | 4c. County of Death
Carroll | | |
| Funeral
Director | 5. Social Security Number
219-54-7520 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
3-13-1905 | | |
| | 10e. State
MD | | 10b. County
Carroll | | 10c. City, Town or Location
Sykesville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 Collega (1-4or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Domestic | | | |
| 17. Father's Name (First, Middle, Last)
John H. Hines | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Murphy | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Dorothy Clark (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 11 Glenelg, MD 21737 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Emmanuel U.M. Cemetery | | 20c. Location - City or Town, State
7/10/97 Scaggsville, MD | | | |
| 21. Signature of Funeral Service Licensee
Brian [Signature] | | | | 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195)
Sykesville, MD 21784 (410)-795-1400 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Dehydration, 3 Cardio pulmonary
Due to (or as a consequence of):
cancer. 3) Poor P.O. intake

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Squamous cell car Skin
Due to (or as a consequence of):
c. [Signature]
d. | | | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HTN. Dementia Alzheimer.
Bilateral Core Vision. Old CVA | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Brian [Signature] | | 29c. License number
D30119 | | 29d. Date signed (Month, Day, Year)
7/7/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAWDA SIDDIE 6212 Sykesville Rd Sykesville MD 21784 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 09 1997 | | | | 32. Registrar's Signature
Judi [Signature] | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22328

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel Grove Bosworth

2. Date of Death

Month Day Year
July 14, 1997

3. Time of Death

5:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

180-28-5207

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 11, 1903

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Fishing Creek

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

2630 Hoopers Island Road

10f. Zip Code

21634

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

William H. Grove

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Bower

19a. Informant's Name/Relationship (Type, Print)

John G. Bosworth Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 238 Fishing Creek, Maryland 21634

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wildwood Cemetery

Date

7/19/97

20c. Location - City or Town, State

Williamsport, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home, P.A.

700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiac Arrest/Hypoxia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 min

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Disease/Total Stroke

Advanced Age

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26388

29d. Date signed (Month, Day, Year)

7-15-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Fadden, MD 408 Byrn St., Cambridge MD 21613

31. Date filed (Month, Day, Year)

JUL 16 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

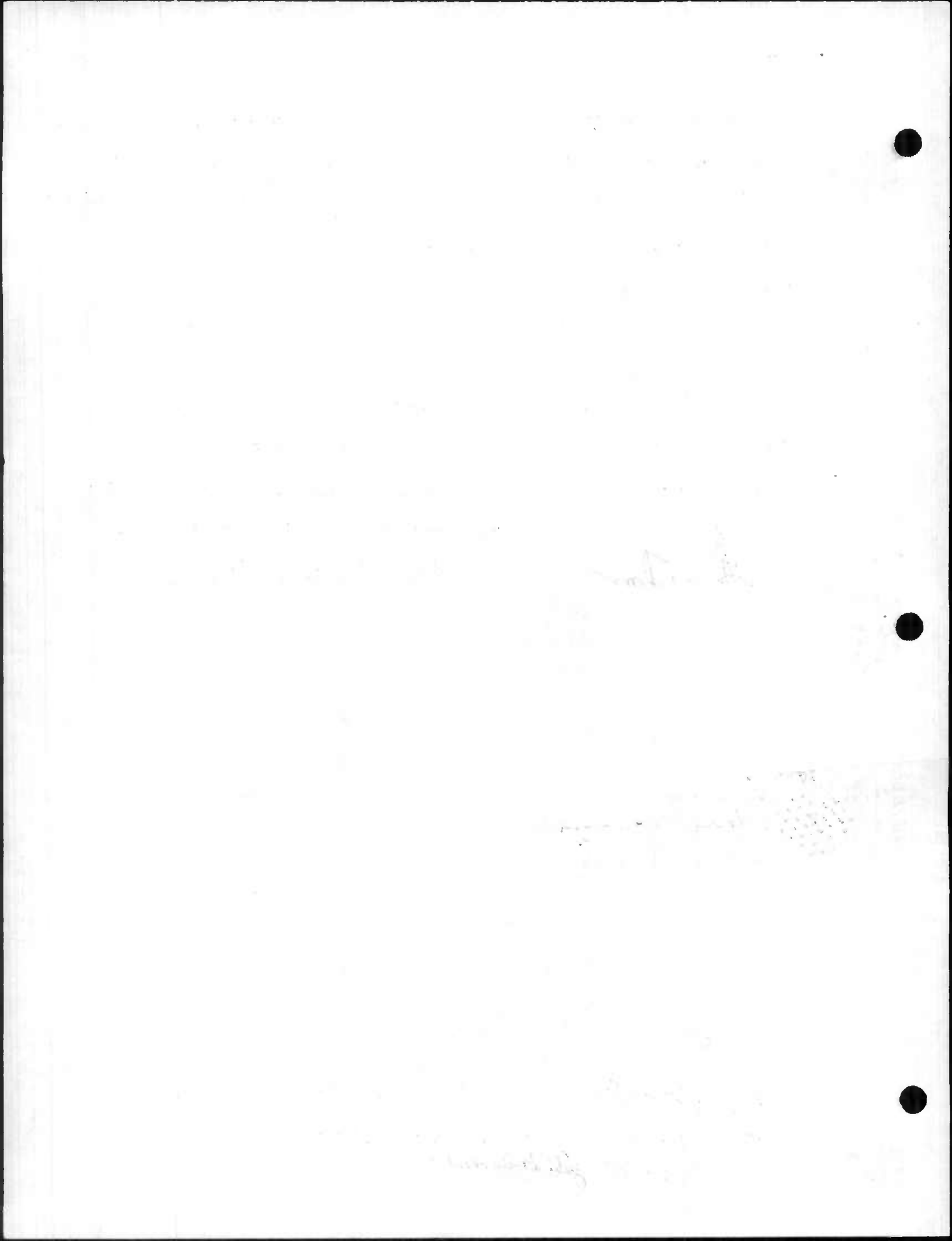
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22329

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HARRY L BERNSTEIN | | | | 2. Date of Death
Month July Day 3 Year 1997 | | 3. Time of Death
7:19PM | |
| | 4e. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
084-07-4395 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
Apr. 21, 1907 | |
| | 9. Birthplace (State or Foreign Country)
New York | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
6121 Montrose Road | | 10f. Zip Code
20852 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Children's Clothes Cutter | | 16b. Kind of Business/Industry
Private Firm | | | | |
| 17. Father's Name (First, Middle, Last)
Hyman Bernstein | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Ida Ginsberg | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Brenda Wagschal/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2839 Aquarius Ave. Silver Spring, MD 20906 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Montefiore Cem. | | Date
7/6/97 | | 20c. Location - City or Town, State
Pinelawn, LI, NY | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Ives-Pearson Funeral Homes
Falls Church, VA 22046 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | Approximate Interval Between Onset and Death
7 days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D37891 | | 29d. Date signed (Month, Day, Year)
July 3 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A RAJIVANSHI MD 121 Congressional Ln #409 Rockville MD 20852 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 08 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

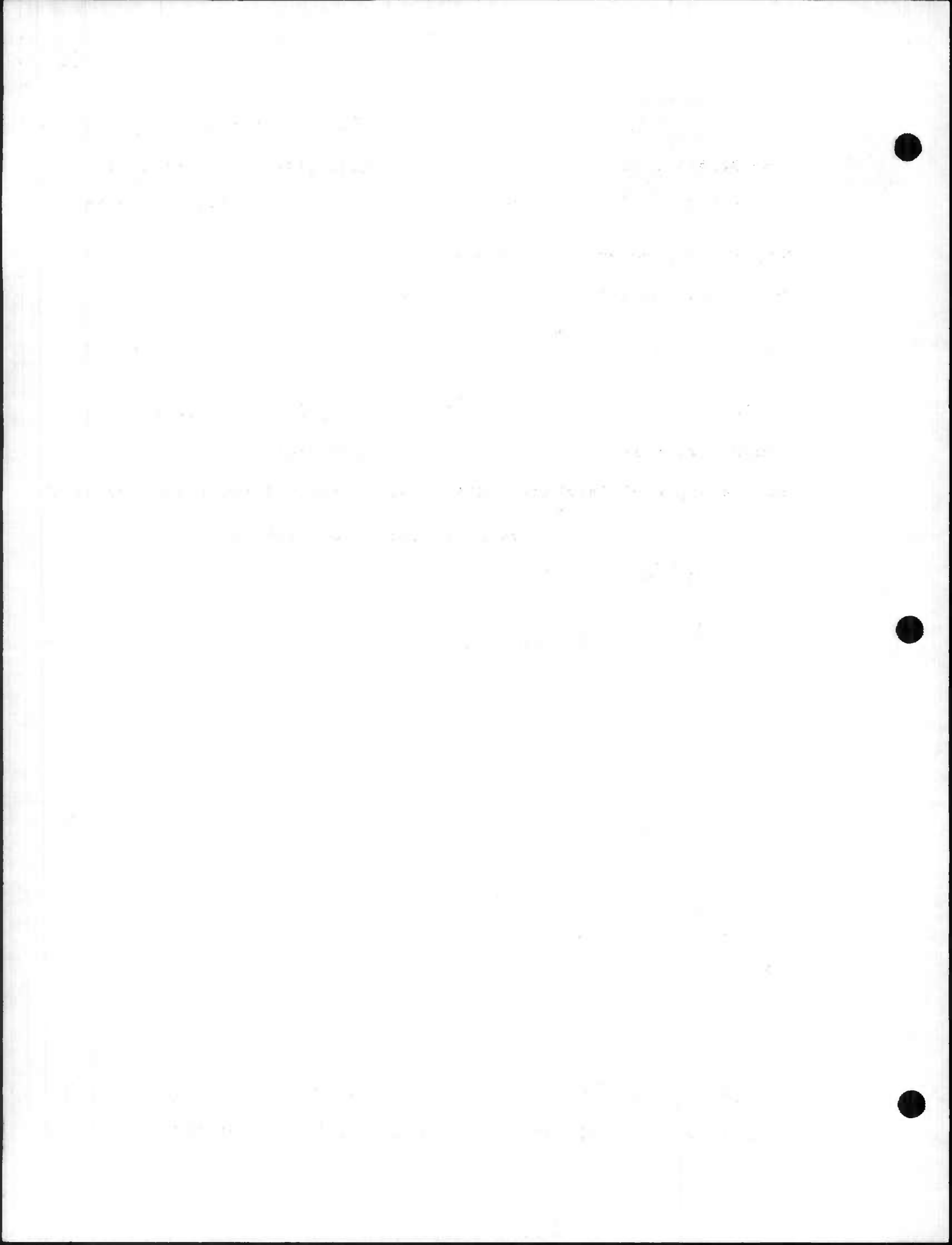
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22330

| | | | | | | | | | |
|---|--|---|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary A. Blake | | | | 2. Date of Death
Month July Day 8 Year 1997 | | 3. Time of Death
7:35 A. M. | | |
| | 4a. Facility Name (If not institution, give street and number)
Larkin Chase Nursing Home | | | | 4b. City, Town, or Location of Death
Bowie | | 4c. County of Death
Prince George | | |
| Funeral
Director | 5. Social Security Number
091-01-1098 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
96 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 24, 1900 | | |
| | 9. Birthplace (State or Foreign Country)
New York | | 10a. State
MD | | 10b. County
Prince George | | 10c. City, Town or Location
Bowie | | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
15005 Health Center Drive | | 10f. Zip Code
20716 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Secretarial | | | | | |
| 17. Father's Name (First, Middle, Last)
Stanley Jahoda | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Schbeck | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mary A. Kemp - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2301 Jefferson Davis Highway Arlington, VA 22202 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Cemetery | | 20c. Location - City or Town, State
7/11/97 Queens, New York | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Joseph Gawler's Sons
5130 Wisconsin Ave. NW Washington, D. C. 20016 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure
Due to (or as a consequence of):
b. Senility
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dysphagia | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D-34525 | | 29d. Date signed (Month, Day, Year)
July 8, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. S. Rao, M. D. 4000 Mitchellville Road #220 Bowie, MD 20716-3101 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 11 1997 | | | | 32. Registrar's Signature
 | | | | | |

Item:23a part I per ME0 G-750 8/6/97 dh part II

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DONALD SIEGURD BLOMQUIST | | | | 2. Date of Death
Month Day Year
JULY 04 1997 | | 3. Time of Death
7:00 AM | |
| | 4e. Facility Name (If not institution, give street and number)
WEST RIVER YACHT CLUB | | | | 4b. City, Town, or Location of Death
GALESVILLE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
528-48-6084 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (in yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG. 3, 1937 | |
| | 9. Birthplace (State or Foreign Country)
UTAH | | 10a. State
VIRGINIA | | 10b. County
FAIRFAX | | 10c. City, Town or Location
VIENNA | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
2818 CEDAR LANE | | 10f. Zip Code
22180 | |
| | 10g. Citizen of What Country?
U.S.A | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify:
WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
5+ | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DIVISION CHIEF | | | | 16b. Kind of Business/Industry
N.I.S.T | | 17. Father's Name (First, Middle, Last)
SIEGURD ANDREW BLOMQUIST | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
ESTHER ERICKSON | | | | 19a. Informant's Name/Relationship (Type, Print)
LINDA LAMOREUX BLOMQUIST/WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2818 CEDAR LANE, VIENNA, VIRGINIA 22180 | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY | | 20c. Location - City or Town, State
ALEXANDRIA, VA | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
<i>Ernest L. Myer</i> | | | | 22. Name and Address of Facility
MONEY & KING VIENNA FUNERAL HOME, INC.
171 WEST MAPLE AVE. VIENNA, VIRGINIA 22180 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
DROWNING AND ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
e. <i>Drowning</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year)
FEB 24 1997 | | | | 28b. Time of Injury
0630 M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred
subject tangled in boat fire and drowned | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
water near pier | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Pier 1 West River Yacht Club in Anne Arundel County | |
| | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>Theodore H. King</i> | | 29c. License number
O.C.M.E. | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)
JULY 04, 1997 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE H. KING
111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
JUL 07 1997 | |
| | 32. Registrar's Signature
<i>John Davidson-Rendell</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22332

| | | | | | | | | | | | | |
|---|--|-----------------|---|---|---|---|---|--|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Virginia Stachura Bollinger | | | | | 2. Date of Death
Month July Day 5 Year 1997 | | 3. Time of Death
1:00 AM | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | | | | |
| Funeral
Director | 5. Social Security Number
217-34-1246 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 16, 1936 | | 9. Birthplace (State or Foreign Country)
Texas | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
11421 Ashley Drive | | | | 10f. Zip Code
20852 | | 10g. Citizen of What Country?
United States | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Customer Service Representative | | | 16b. Kind of Business/Industry
Banking | | | | |
| | 17. Father's Name (First, Middle, Last)
John Thomas Stachura, Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ruth Virginia Chapman | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lester Elwood Bollinger/Husband | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11421 Ashley Drive, Rockville, Maryland 20852 | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Memorial Gardens | | | 20c. Location - City or Town, State
Frederick, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| | <table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:60%;"> a. Stroke - massive; right mca territory
 Due to (or as a consequence of):
 b. Hyperlipidemia
 Due to (or as a consequence of):
 c.
 Due to (or as a consequence of):
 d. </td> <td style="width:10%;"> 60 Hours </td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Stroke - massive; right mca territory
Due to (or as a consequence of):
b. Hyperlipidemia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. |
| Immediate Cause (Final disease or condition resulting in death) | a. Stroke - massive; right mca territory
Due to (or as a consequence of):
b. Hyperlipidemia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | 60 Hours | | | | | | | | | | |

| | | | |
|---|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CAD

Hypertension | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
|---|--|--|--|

| | | | | | | | | | |
|---|--|---|--|---------------------------------|--------------------------------------|--|---|-----------------------------------|--|
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner : On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D46052 | | 29d. Date signed (Month, Day, Year)
June 5th, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
SPENCE BECK, MD Old Georgetown Road, Bethesda, Maryland 20814 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 08 1997 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22333

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Stanley L. Borowiec | | | | 2. Date of Death
Month July Day 9 Year 1997 | | 3. Time of Death
5:00PM | |
| | 4a. Facility Name (If not institution, give street and number)
Sligo Creek Nursing & Rehabilitation Center | | | | 4b. City, Town, or Location of Death
Takoma Park | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
364-03-8805 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 30, 1915 | |
| | 9. Birthplace (State or Foreign Country)
Michigan | | 10a. State
MD | | 10b. County
Prince Georges | | 10c. City, Town or Location
Hyattsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 Yes 2 No | | 10e. Street and Number
8229 New Hampshire Avenue | | 10f. Zip Code
20783 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Stock Clerk | | 16b. Kind of Business/Industry
Federal Government | | | |
| | 17. Father's Name (First, Middle, Last)
Albert Borowiec | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Victoria Pietras | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Margaret A. Armas | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7502 Hancock Avenue, Takoma Park, MD 20912 | | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | Date
7/12/97 | | 20c. Location - City or Town, State
Brentwood, MD | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Prostate Cancer with Metastasis
Due to (or as a consequence of):

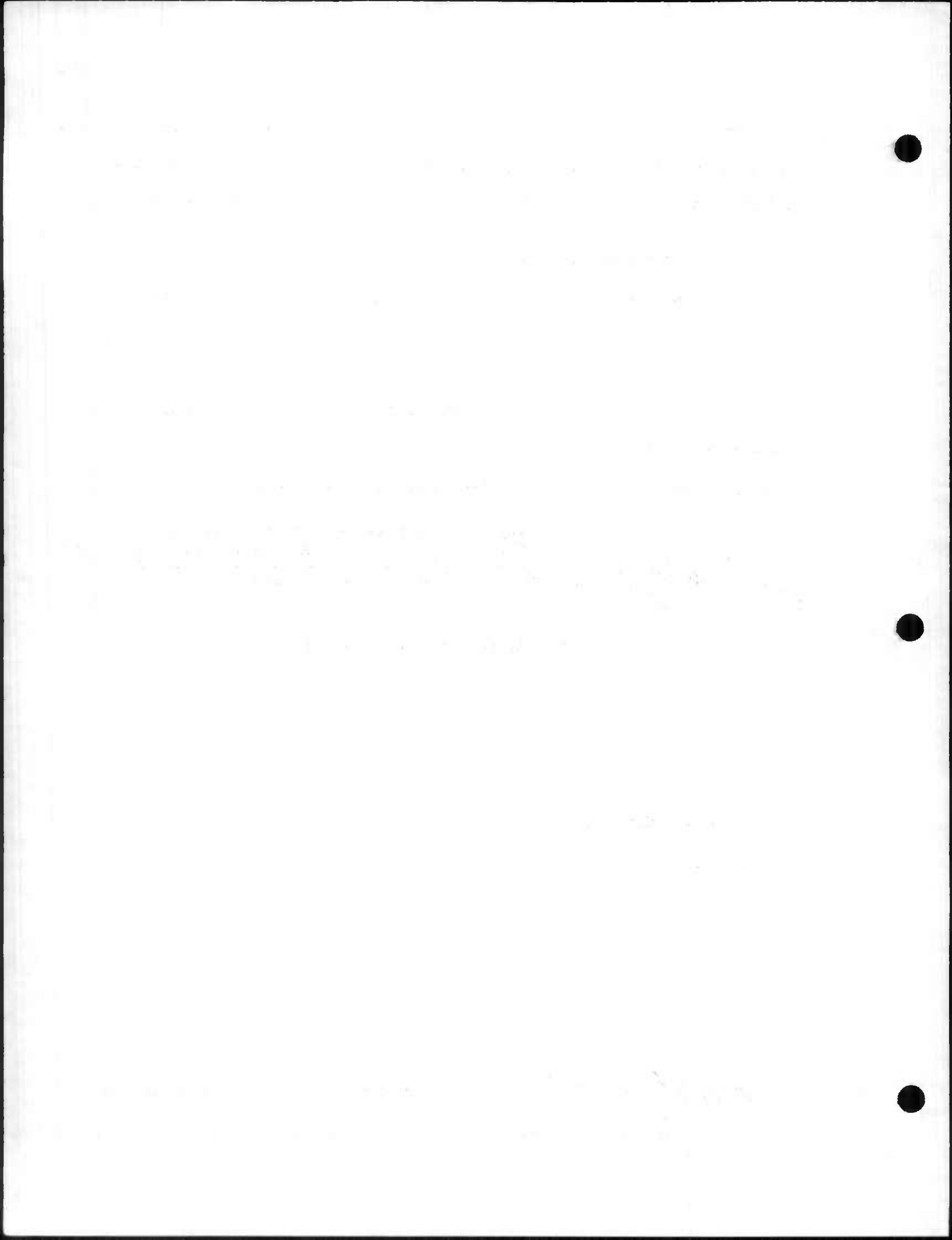
b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 Yes 2 No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Laryngeal Carcinoma

Dehydration | | | | | | | |
| | 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| | 27. Manner of Death
1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D14404 | | 29d. Date signed (Month, Day, Year)
July 10, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles L. Franklin, Jr., M.D., 11120 New Hampshire Ave., Silver Spring, MD 20904 | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUL 11 1997 | | | | 32. Registrar's Signature
 | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22334

| | | | | | | | | | |
|--|---|---|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THOMAS ALDEN BRADFORD, JR. | | | | 2. Date of Death
Month Day Year
JULY 10, 1997 | | 3. Time of Death
1:15 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
10325 SEVEN LOCKS ROAD | | | | 4b. City, Town, or Location of Death
POTOMAC | | 4c. County of Death
MONTGOMERY | | |
| Funeral
Director | 5. Social Security Number
577-52-5579 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
63 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
FEB. 28, 1934 | | 9. Birthplace (State or Foreign Country)
WASHINGTON, D.C. | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
MONTGOMERY | | 10c. City, Town or Location
POTOMAC | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
10325 SEVEN LOCKS ROAD | | | 10f. Zip Code
20854 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 57-58 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
+4 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
RESTAURANT | | | 16b. Kind of Business/Industry
RESTAURATEUR | | |
| | 17. Father's Name (First, Middle, Last)
THOMAS ALDEN BRADFORD, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
RUTH THOMAS | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
MARIA TOUCEDA BRADFORD WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10325 SEVEN LOCKS ROAD, POTOMAC, MD 20854 | | | | |
| | 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARKLAWN MEMORIAL PARK | | Date
7/12/97 | | 20c. Location - City or Town, State
ROCKVILLE, MARYLAND | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOSEPH GAWLER'S SONS, INC.
5130 WI AVENUE, NW, WASHINGTON, D.C. 20016 | | | | |
| | 23e. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. METASTATIC MELANOMA
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Approximate Interval Between Onset and Death
2 MONTHS | | | | | | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D C 11506 | | 29d. Date signed (Month, Day, Year)
JULY 10, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
FRED SMITH, M.D. 5401 WESTERN AVENUE, N.W., WASHINGTON, D.C. 20015 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 11 1997 | | | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22335

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Viola

R.

Browning

2. Date of Death

July 6, 1997

3. Time of Death

6:00 P.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

7301 Radcliffe Drive

4b. City, Town, or Location of Death

College Park

4c. County of Death

Prince George's

5. Social Security Number

579-05-1128

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 17, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Prince George's10c. City, Town or Location
College Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7301 Radcliffe Drive

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

W.S.S.C.

17. Father's Name (First, Middle, Last)

John

Raines

18. Mother's Name (First, Middle, Maiden Surname)

Emma

Shackford

19a. Informant's Name/Relationship (Type, Print)

Frank M.W. Browning (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ft. Lincoln Cemetery 7/10/1997

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CEREBRO VASCULAR ACCIDENT

Approximate
Interval Between
Onset and Death

3 MONTHS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. HYPERTENSION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETIS MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph K. Mathew

29c. License number

D14799

29d. Date signed (Month, Day, Year)

July 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph K. Mathew, M.D. 6510 Kenilworth Ave., #1400 Riverdale, Maryland 20737

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

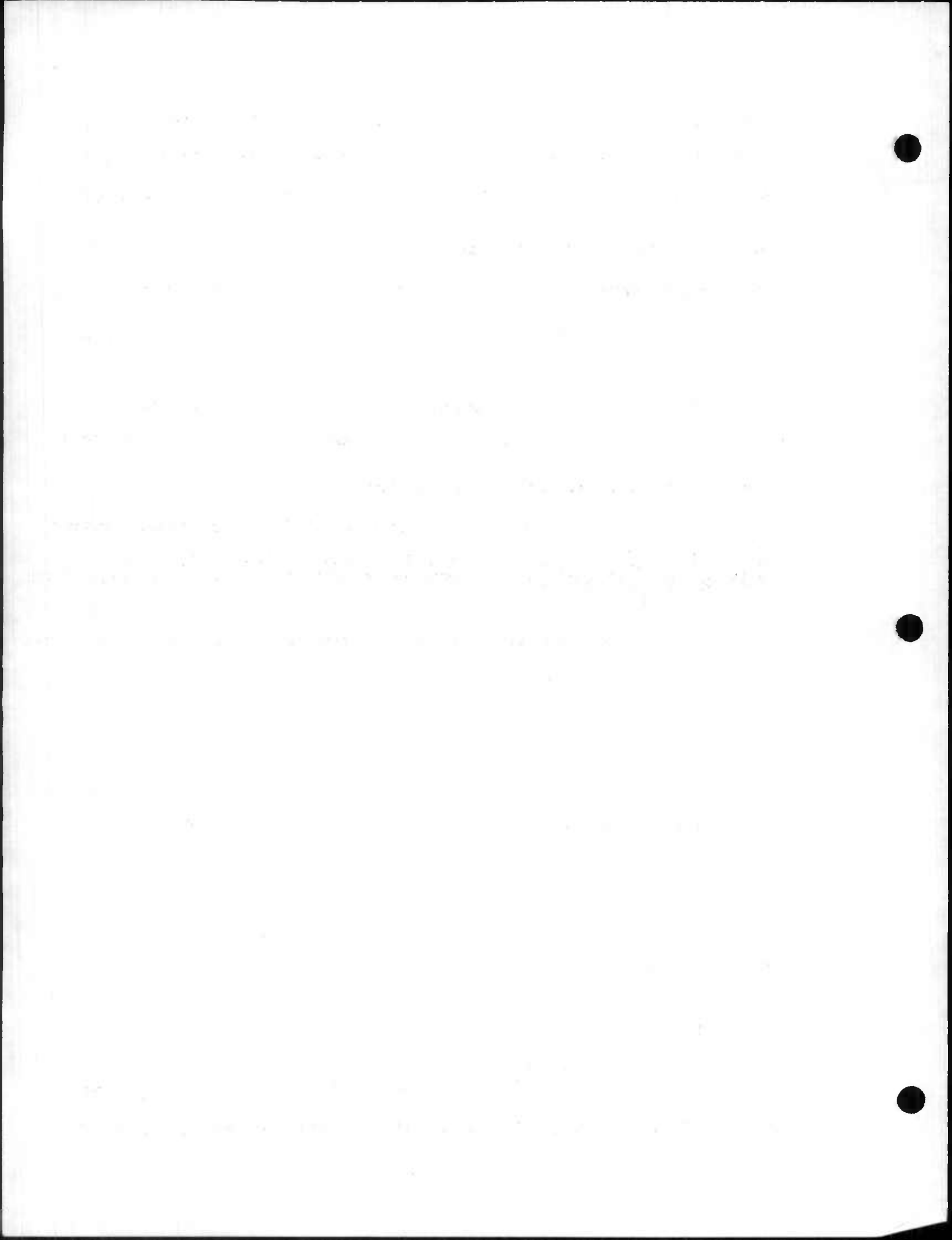
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22336

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lois I. Bruce

2. Date of Death
Month Day Year

July 4 1997

3. Time of Death

10:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

11235 Oak Leaf Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-18-3554

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

March 23, 1909

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

11235 Oak Leaf Drive

10f. Zip Code

20905

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

George A. Mount

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Vann

19a. Informant's Name/Relationship (Type, Print)

Joseph A. Bruce

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9206 Fairhaven Avenue Upper Marlboro, Maryland 20772

20a. Method of Disposition

☒ Burial ☐ Cremation ☒ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Andalusia (Magnolia) Cemetery

20c. Location - City or Town, State

Andalusia, Alabama

21. Signature of Funeral Service Licensee

William J. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Breast

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of injury
(Month, Day Year)

28b. Time of injury

28c. Injury at work?

☐ Yes ☐ No

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pamela M. Mulshine, M.D.

29c. License number

D20009

29d. Date signed (Month, Day, Year)

July 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pamela M. Mulshine, M.D. 11251 Lockwood Drive Silver Spring, Maryland 20901

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

Julia Davidson-Pendall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

30

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22337

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | | 1. Decedent's Name (First, Middle, Last)
<div align="center">Eunice Fay Burke</div> | | | | 2. Date of Death
Month Day Year
July 3, 1997 | | 3. Time of Death
8:15 AM | | | |
| | | 4a. Facility Name (If not institution, give street and number)
1210 Thornden Road | | | | 4b. City, Town, or Location of Death
Rockville | | 4c. County of Death
Montgomery | | | |
| Funeral
Director | | 5. Social Security Number
235-36-3063 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 8, 1926 | | 9. Birthplace (State or Foreign Country)
West Virginia | |
| | | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 10e. Street and Number
1210 Thornden Road | | | | 10f. Zip Code
20851 | | 10g. Citizen of What Country?
United States | | | |
| | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
homemaker | | | 16b. Kind of Business/Industry
own home | | | | |
| Physician
/Medical
Examiner | | 17. Father's Name (First, Middle, Last)
Arthur Wilmoth | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Allie Ferguson | | | | | |
| | | 19a. Informant's Name/Relationship (Type, Print)
Timothy A. Burke | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Same as 10 | | | | | |
| | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | Data
7-4-97 | | 20c. Location - City or Town, State
Beltsville, Maryland | | | |
| | | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 20910 | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; align-items: flex-start;"> <div style="margin-right: 10px;"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </div> <div> a. Severe Parkinson's Disease
 Dua to (or as a consequence of):
 b. Severe Dementia
 Dua to (or as a consequence of):
 c.
 Dua to (or as a consequence of):
 d. </div> </div> | | | | | | | | Approximate Interval Between Onset and Death | |
| | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism; Osteoarthritis
Reflux Esophagitis | | | | | | | | | |
| | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | |
| | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | | | 29c. License number
D 27301 | | 29d. Date signed (Month, Day, Year)
July 3, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Douglas R. Shumaker, M. D., 615 West Montgomery Avenue, Rockville, MD 20850 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 07 1997 | | | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel

Byler

2. Date of Death

Month Day Year
June 21, 1997

3. Time of Death

12:45 P.M.

4a. Facility Name (If not institution, give street and number)

Mariner Health Care

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-32-8285

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Apr. 30, 1897

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3000 McComas Ave.

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

James Byler

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Gay

19a. Informant's Name/Relationship (Type, Print)

James Coyle/nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8407 Park Crest Dr. Silver Spring, MD 20910

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory June 27, 1997 Alexandria, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Takoma Funeral Home, Inc.
254 Carroll St. NW Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GRAM NEGATIVE SEPTICEMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSON'S Disease

DIABETE MELLITUS TYPE II

STROKE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D36046

29d. Date signed (Month, Day, Year)

6/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN J. MCKENPINO JR., MD

4701 RANDOLPH RD 216
ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22339

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nicoletta Barotti

2. Date of Death

Month Day Year
July 7, 1997

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

13515 Sanderling Place

4b. City, Town, or Location of Death

Germantown

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

123-22-4980

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 17, 1930

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13515 Sanderling Place

10f. Zip Code

20874

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Coding Supervisor

16b. Kind of Business/Industry

Insurance Company

17. Father's Name (First, Middle, Last)

Pasquale LaMattina

18. Mother's Name (First, Middle, Maiden Surname)

Julimina (Not Available)

19a. Informant's Name/Relationship (Type, Print)

William R. Barotti/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13515 Sanderling Place, Germantown, MD 20874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

July 10, 1997

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee



M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Metastatic Colon Cancer

Approximate
Interval Between
Onset and Death

3 Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

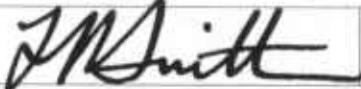
27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D33293

29d. Date signed (Month, Day, Year)

July 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick P. Smith, M.D. 5401 Western Avenue, NW Washington, D.C. 20015

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature
State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22340

| | | | | | | | | | |
|---|---|--|--|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lester Baker, Jr. | | | | 2. Date of Death
Month Day Year
JULY 4, 1997 | | 3. Time of Death
18:42 | | |
| | 4a. Facility Name (If not institution, give street and number)
St. Agnes Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
(City) | | |
| Funeral
Director | 5. Social Security Number
246-30-0486 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
Apr. 11, 1925 | | |
| | 9. Birthplace (State or Foreign Country)
N. Carolina | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Laurel | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3515 Oak Grove Road | | 10f. Zip Code
20824 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 51-52 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Driver | | 16b. Kind of Business/Industry
Automotive Warehouse | | 17. Father's Name (First, Middle, Last)
Lester Baker, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Unknown | |
| 19a. Informant's Name/Relationship (Type, Print)
John Carter (Grand-son) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3579 Whiskey Bottom Rd., Laurel, MD 20724 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Zion Church Cem. | | 20c. Location - City or Town, State
7/12/97 Laurel, MD | |
| 21. Signature of Funeral Service Licensee
<i>George R. Snowden</i> | | 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

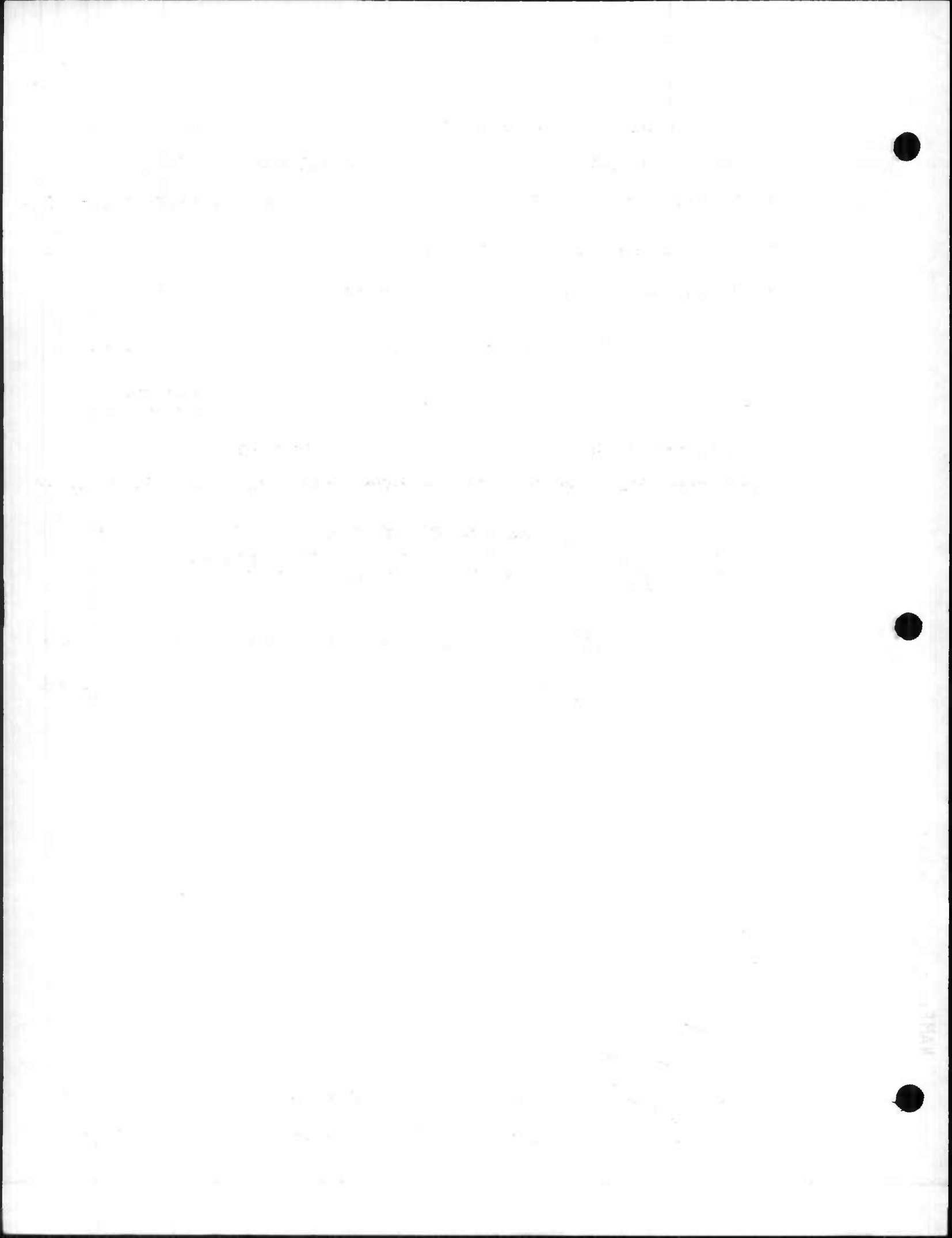
Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic coronary vessel disease
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
1 hour
10 years | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Physician</i> | | 29c. License number
D050907 | | 29d. Date signed (Month, Day, Year)
July 4th, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kraig A. McVile MD 900 South Caton Avenue, Baltimore, Maryland | | 31. Date filed (Month, Day, Year)
JUL 10 1997 | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22341

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Howard O. Bachman

2. Date of Death

Month
JulyDay
8Year
1997

3. Time of Death

12:13 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-12-2850

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Aug. 15, 1920

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4621 Aspen Hill Road

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1945-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Repairman

16b. Kind of Business/Industry

Telephone

17. Father's Name (First, Middle, Last)

Wendel Bachman

18. Mother's Name (First, Middle, Maiden Surname)

Emily Bourdeaux

19a. Informant's Name/Relationship (Type, Print)

Dorothy M. Bachman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4621 Aspen Hill Road, Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donellon 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD Veteran's Cemetery

Date

7/14/97

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

Kevin Gutowski

22. Name and Address of Facility

Francis J. Collins Funeral

Home, Inc. 500 University Blvd. West

Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction

Due to (or as a consequence of):

Terminal

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. arteriosclerotic heart disease

Due to (or as a consequence of):

2 yrs

c. generalized atherosclerosis

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

prior stroke with hemiplegia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

26a. Date of Injury

(Month, Day, Year)

26b. Time of Injury

M

26c. Injury at Work?

1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George F. Sengstack, M.D.

29c. License number

D12121

29d. Date signed (Month, Day, Year)

7-8-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George F. Sengstack, M.D.--3929 Ferrara Drive; Wheaton, MD 20906

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22342

| | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gilliam Austeen Bratcher, Jr. | | | | 2. Date of Death
Month 07 Day 04 Year 1997 | | 3. Time of Death
1821 | | |
| | 4a. Facility Name (If not institution, give street and number)
Harford Memorial Hospital | | | | 4b. City, Town, or Location of Death
Havre de Grace | | 4c. County of Death
Harford | | |
| Funeral
Director | 5. Social Security Number
236-32-0966 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
04/10/1927 | 9. Birthplace (State or Foreign Country)
W. VA | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Cecil | | 10c. City, Town or Location
Conowingo | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
1054 Liberty Grove Road | | | | 10f. Zip Code
21918 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
1-4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Aviation | | 16b. Kind of Business/Industry
Federal Government | | |
| | 17. Father's Name (First, Middle, Last)
Gilliam Austeen Bratcher, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sadie Halsey | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Anneliese J. Bratcher- Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1054 Liberty Grove Rd. Conowingo, MD 21918 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Nottingham Cem. | | Data
07/10/97 | | 20c. Location - City or Town, State
Cecil County, MD | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Mitchell-Smith Funeral Home
123 S. Washington St. Havre de Grace, MD | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic cardiovascular disease years
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
{
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease
Chronic ethanol abuse | | | | | | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
7/5/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SMIALEK | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 7 1997 | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22343

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|--|--|--|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDGAR BOWERS | | | | 2. Date of Death
Month Day Year
July 3, 1997 | | | | 3. Time of Death
10:10 AM | | | |
| | 4a. Facility Name (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death
CLINTON | | | | 4c. County of Death
PRINCE GEORGE'S | | | |
| Funeral
Director | 5. Social Security Number
579 24 7594 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB 27, 1923 | | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | | | 10b. County
P.G. | | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
SILVER HILL | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
3809 PARK BLVD. | | | |
| | 10f. Zip Code
20746 | | | | 10g. Citizen of What Country?
UNITED STATES | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | |
| | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII
If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
REAL ESTATE | | | | 16b. Kind of Business/Industry
REAL ESTATE | | | |
| | 17. Father's Name (First, Middle, Last)
LUTHER CURTIS BOWERS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
HATTIE HEISHMAN | | | | 19a. Informant's Name/Relationship (Type, Print)
ALICE H. BOWERS | | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3809 PARK BLVD. SILVER HILL, MD 20746 | | | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
JULY 9, 1997
MARYLAND VETERANS CEMETERY | | | |
| | 20c. Location - City or Town, State
CHELTHENHAM, MARYLAND | | | | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
LEE FUNERAL HOME, INC 6633 OLD ALEXANDRIA FERRY RD, CLINTON, MD 20735 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA OF LUNG
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
3 Years | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA
COPD | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D46478 | | 29d. Date signed (Month, Day, Year)
7.3.97 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
SURESH A. PATEL, MD 7501 SURRATTS RD, #307, CLINTON, MD 20735 | | | | |
| 31. Date filed (Month, Day, Year)
JUL 15 1997 | | | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

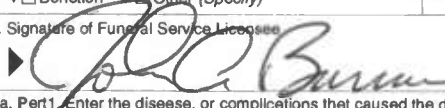
Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

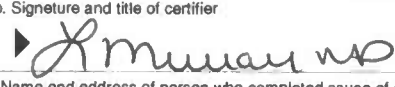
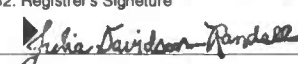
State of Maryland / Department of Health and Mental Hygiene **97 22344**
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eleanor Fallon Barbour | | | | 2. Date of Death
Month Day Year
July 11, 1997 | | 3. Time of Death
11:30am | |
| | 4a. Facility Name (If not institution, give street and number)
1426 Medinah Court | | | | 4b. City, Town, or Location of Death
Arnold | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
022-18-9791 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 28, 1921 | |
| | 9. Birthplace (State or Foreign Country)
Mass. | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Arnold | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
1426 Medinah Court | | 10f. Zip Code
21012 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | 16b. Kind of Business/Industry
Education | | | |
| | 17. Father's Name (First, Middle, Last)
Martin Fallon | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Katherine Wilbur | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Charles W. Barbour/husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1426 Medinah Court, Arnold, MD 21012 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Cemetery | | 20c. Location - City or Town, State
Davidsonville, MD | | 20d. Date
July 15 1997 | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | |
| | 23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Sepsis
Due to (or as a consequence of):
b. Radiation enteritis
Due to (or as a consequence of):
c. Uterine cancer
Due to (or as a consequence of):
d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier

LISA MURRAY MD | | | | 29c. License number
D38526 | | 29d. Date signed (Month, Day, Year)
7/11/97 | |
| State
Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
LISA MURRAY, MD 600 Bridgley Ave S120 Annapolis MD 21401 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 14 1997 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22345

| | | | | | | | | |
|---|---|---|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARTHA BELL | | | | 2. Date of Death
Month JULY 10 Day 1997 Year | | 3. Time of Death
0930 | |
| | 4a. Facility Name (If not Institution, give street and number)
REGENCY NURSING & REHAB. CENTER | | | | 4b. City, Town, or Location of Death
FORESTVILLE | | 4c. County of Death
PRINCE GEORGE | |
| Funeral
Director | 5. Social Security Number
218-07-9643 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JULY 14 1910 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
LOTHIAN | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
1147 MARLBORO ROAD | | | | 10f. Zip Code
20711 | | 10g. Citizen of What Country?
US | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | |
| | 17. Father's Name (First, Middle, Last)
THOMAS WILSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MAGGIE SOLLERS | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MAGGIE SMITH (COUSIN) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1400 MARLBORO RD. LOTHIAN, MD. 20711 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOSES CEMETERY | | Date
7/15/97 | | 20c. Location - City or Town, State
DRURY, MARYLAND | |
| | 21. Signature of Funeral Service Licensee
Harry B. Reese | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Ischemic Cardiomyopathy, Diabetes Mellitus
Chronic anemia | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
George C. Hajjar, Jr. | | | | 29c. License number
039550 | | 29d. Date signed (Month, Day, Year)
7/11/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, Md. 20706 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 14 1997 | | 32. Registrar's Signature
Julia Davidson | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

245342

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

OFFICE OF THE CHIEF OF BUREAU

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22346

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary E. Brown

2. Date of Death

July 10 1997 9:25 AM

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

WINDSOR RIDGE Nursing and Rehab

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

213-22-0476

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN. 10 1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GAMBRILLS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1188 SUMMERFIELD ROAD

10f. Zip Code

21054

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

1yr.

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

HOUSEKEEPING
FT. GEORGE MEADE

17. Father's Name (First, Middle, Last)

ANDREW PINDELL

18. Mother's Name (First, Middle, Maiden Surname)

MARY WILLIAMS

19e. Informant's Name/Relationship (Type, Print)

LAWRENCE BROWN (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1188 SUMMERFIELD RD. GAMBRILLS, MD. 21054

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. TABOR CHURCH CEMETERY

Date

7/16/97

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

Larry H. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. ESRD
Due to (or as a consequence of):b. HTN
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

months

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

037573

29d. Date signed (Month, Day, Year)

July 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jef Zibell MD 7220 Park Heights Ave Baltimore MD 21208

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22347

| | | | | | | | | | | | |
|---|--|--|---|--|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Richard A. Bruinsma | | | | 2. Date of Death
Month Day Year
July 09 1997 | | 3. Time of Death
2:17AM | | | | |
| | 4a. Facility Name (If not institution, give street and number)
North Arundel Hospital | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | | | | |
| Funeral
Director | 5. Social Security Number
013-24-5640 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 5 1932 | | 9. Birthplace (State or Foreign Country)
Massachusetts | | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Crownsville | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number
1252 Generals Highway | | | | 10f. Zip Code
21032 | | 10g. Citizen of What Country?
United States | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Minister | | | 16b. Kind of Business/Industry
Religion | | | | |
| 17. Father's Name (First, Middle, Last)
Edward John Bruinsma | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Monica Marcus | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Deayon Bruinsma (Neice) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
524 Cairn Road Millersville, Maryland 21108 | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Crematory | | Date
7/11/97 | | 20c. Location - City or Town, State
Brentwood, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Donald A. Taylor</i> | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial infarction
Due to (or as a consequence of):
b. Atrial Fibrillation
Due to (or as a consequence of):
c. Diabetes mellitus
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
hours
years
years | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, past Acute-Adult
respiratory distress syndrome, 1995.
Deep vein thrombosis 1995 - Coumadin cessation | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Jeffrey E. Atkinson MD</i> | | 29c. License number
043303 | | 29d. Date signed (Month, Day, Year)
7-10-97 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Jeffrey E Atkinson MD 470-D Ritchie Hwy Severna Park MD | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 11 1997 | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22348

| | | | | | | | | | | |
|-------------------------------------|--|--|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Russell Brown | | | | 2. Date of Death
Month Day Year
July 3 1997 | | | | 3. Time of Death
1525 | |
| | 4a. Facility Name (If not institution, give street and number)
Genesis Elder Care | | | | 4b. City, Town, or Location of Death
Randallstown | | | | 4c. County of Death
Baltimore County | |
| Funeral
Director | 5. Social Security Number
215-88-8103 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
33 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
2/28/64 | | 9. Birthplace (State or Foreign Country)
Maryland | | Usual Residence of Decedent | | 10e. State
MD | | 10b. County
Baltimore | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
Essex | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
212 Riverdale Court | | 10f. Zip Code
21202 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
None | | 16b. Kind of Business/Industry
None | | 17. Father's Name (First, Middle, Last)
Clarence E. Brown | | 18. Mother's Name (First, Middle, Maiden Surname)
Nancy R. Snyder | | 19a. Informant's Name/Relationship (Type, Print)
Nancy Bell / Mother | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4317 Sycamore Dr. Hampstead, MD 21074 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hampstead Cemetery | | 20c. Location - City or Town, State
Hampstead, MD | | 21. Signature of Funeral Service Licensee
Steven W. Eline | |
| | 22. Name and Address of Facility
934 S. Main St
Eline Funeral Home Hampstead, MD 21074 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Progressive Multifocal Leukoencephalopathy
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | |
| | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Shelley M. Cabbot | | 29c. License number
D38708 | | 29d. Date signed (Month, Day, Year)
7/7/97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shelley M. Cabbot, 4000 Old Court Road Baltimore, MD 21208 | |
| | 31. Date filed (Month, Day, Year)
JUL 09 1997 | | 32. Registrar's Signature
John Shuckler-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22349

Certificate of Death

Reg. No.

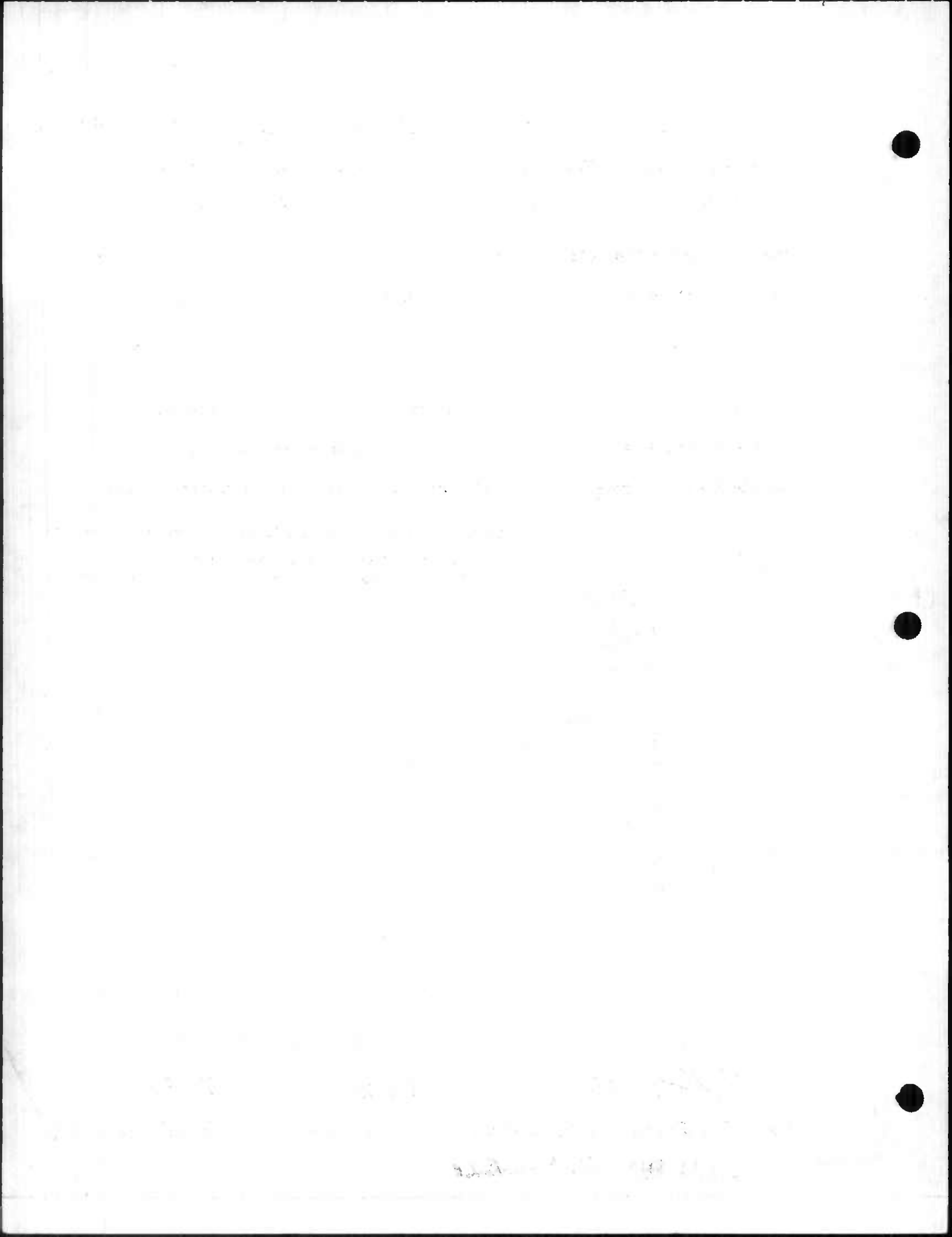
| | | | | | | | | | | |
|--|--|--|---|---|--|--------------------------------------|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>MARTIN G. Beck</i> | | | 2. Date of Death
Month <i>July</i> Day <i>1</i> Year <i>1997</i> | | | 3. Time of Death
<i>4:20 AM</i> | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Washington Adventist Hospital</i> | | | 4b. City, Town, or Location of Death
<i>Takoma Park</i> | | | 4c. County of Death
<i>Montgomery</i> | | | |
| Funeral
Director | 5. Social Security Number
<i>377-24-7672</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>68</i> Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
<i>Jan. 16, 1929</i> | | 9. Birthplace (State or Foreign Country)
<i>Ohio</i> | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | | 10b. County
<i>Prince George's</i> | | 10c. City, Town or Location
<i>Largo</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
<i>24 Cable Hollow Way</i> | | | | 10f. Zip Code
<i>20774</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>Collage</i> | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
<i>Offset Pressman</i> | | | 16b. Kind of Business/Industry
<i>Printing</i> | | |
| | 17. Father's Name (First, Middle, Last)
<i>George Martin Beck</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Alberta Philomena Beesten</i> | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Bonnie Beck - Daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4747 King John Way, Upper Marlboro, MD 20772</i> | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Metropolitan Crematory</i> | | | 20c. Location - City or Town, State
<i>07/02/97 Alexandria, Virginia</i> | | | |
| | 21. Signature of Funeral Service Licensee
<i>Carri Lynn Marsh - Brady</i> | | | 22. Name and Address of Facility
<i>Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781</i> | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. CONGESTIVE HEART FAILURE</i>
Due to (or as a consequence of):
<i>b. SEVERE AORTIC STENOSIS</i>
Due to (or as a consequence of):
<i>c. CORONARY ARTERY DISEASE</i>
Due to (or as a consequence of):
<i>d.</i>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>ACUTE RENAL FAILURE</i>
<i>DIABETES MELLITUS</i> | | | | | | | | | Approximate Interval Between Onset and Death
<i>6 months</i>
<i>1 YEAR</i>
<i>5 YEARS</i> |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>ACUTE RENAL FAILURE</i>
<i>DIABETES MELLITUS</i> | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
<i>ALAN EFSTRATION MD</i> | | | 29c. License number
<i>D46183</i> | | 29d. Date signed (Month, Day, Year)
<i>7-1-97</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>ALAN EFSTRATION MD 1131 UNIVERSITY BLVD WEST #405, SILVER SPRING MD 20902</i> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>JUL 10 1997</i> | | | 32. Registrar's Signature
<i>Jodi Shuckler-Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22350

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|-------------------------------------|--|--|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eleanor Ruth Bergsten | | | | | 2. Date of Death
Month Day Year
July 5, 1997 | | 3. Time of Death
8:53 pm | | |
| | 4e. Facility Name (If not institution, give street and number)
6511 Princess Garden Parkway #4 | | | | | 4b. City, Town, or Location of Death
Lanham | | 4c. County of Death
Prince George's | | |
| Funeral
Director | 5. Social Security Number
048-12-1729 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 3, 1925 | | 9. Birthplace (State or Foreign Country)
Massachusetts | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Lanham | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
6511 Princess Garden Parkway #4 | | | | 10f. Zip Code
20706 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Administrative Assistant | | | 16b. Kind of Business/Industry
College / Education | | |
| | 17. Father's Name (First, Middle, Last)
George Bergsten | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Clara Miller | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Alda T. Kumpfert - Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8908 Woodburn Court, Lanham, Maryland 20706 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lorraine Park Cemetery | | | Date
07/08/97 | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Cancer, Ovarian
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | |
| | Approximate Interval Between Onset and Death
4 Years | | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | | 29c. License number
D38108 | | 29d. Date signed (Month, Day, Year)
070797 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Elise Kohn, M.D. National Institute of Health, Clinical Center, Bethesda, MD | | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUL 10 1997 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

important: if item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22351

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Flossie Brown

2. Date of Death

Month Day Year
July 8, 1997

3. Time of Death

8:14 AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

264-09-8775

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
05-18-07

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bladensburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5999 Emerson Street #701

10f. Zip Code

20710

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3rd

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Anthony King

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Bell

19a. Informant's Name/Relationship (Type, Print)

Carolyn Washington/Granddaughter

1184 Cromwell Avenue #4M, Bronx, NY 10452

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

7/14/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perceutic

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY INSUFFICIENCY 4 Hours

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 6 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Hand MD

29c. License number

D04899

29d. Date signed (Month, Day, Year)

7/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DENNIS J. HAND MD 4203 QUEENSBURY RD. HYATTSVILLE 20710

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22352

| | | | | | | | | | | | | |
|--|---|---|---|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY W. BIGSBY | | | | 2. Date of Death
Month JULY Day 3, Year 1997 | | 3. Time of Death
2:10 AM | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
NATIONAL LUTHERAN HOME | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | | | | | |
| Funeral
Director | 5. Social Security Number
215-03-2158 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
100 Yrs. | | 8. Date of Birth (Month, Day, Year)
DEC. 6, 1896 | | 9. Birthplace (State or Foreign Country)
SCOTLAND | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
BALTIMORE CITY | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
513- E. 38th STREET | | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
U.S.A | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALES PERSON | | | 16b. Kind of Business/Industry
NOT AVAILABLE | | | | |
| | 17. Father's Name (First, Middle, Last)
JAMES EWAN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARY W. ELDER | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
REV. DR. REICHARD | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9701- VEIRS DR., ROCKVILLE, MD. 20850 | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GLENWOOD CEMETERY | | 20c. Location - City or Town, State
WASH., DC | | 20d. Date
7/7/97 | | | | |
| | 21. Signature of Funeral Service Licensee
W. M. Ayres | | | | 22. Name and Address of Facility
HYSONG CO., INC.
1300- N ST., NW, WASH., DC | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Chronic Blood loss Anemia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Diverticulosis
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
6 months
30 years | |
| | To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Some Cachexia Congestive Heart Failure
Atrial Fibrillation, Cardiomegaly
Ischemia | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Christopher Schemm | | 29c. License number
D36618 | | 29d. Date signed (Month, Day, Year)
July 3rd 1997 | | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. CHRISTOPHER SCHEMM- 9701- VEIRS DR., ROCKVILLE, MD. | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 09 1997 | | | | 32. Registrar's Signature
John Michael Rader | | | | | | | |

NOT TO BE USED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22353

Reg. No.

**Physician
/Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
EVELYN L. BRITTAIN | | | | 2. Date of Death
Month JULY 9, Day 1997 Year | | 3. Time of Death
8:40 PM | |
| 4a. Facility Name (If not institution, give street and number)
MARINER HEALTH CARE OF SILVER SPRING | | | | 4b. City, Town, or Location of Death
SILVER SPRING | | 4c. County of Death
MONTGOMERY COUNTY | |
| 5. Social Security Number
218-12-6744 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG. 26, 1922 | |
| 9. Birthplace (State or Foreign Country)
WASHINGTON, DC | | Usual Residence of Decedent | | | | | |
| 10a. State
MARYLAND | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
SILVER SPRING | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
9118 SUDBURY ROAD | | | | 10f. Zip Code
20901 | | 10g. Citizen of What Country?
UNITED STATES | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CLERICAL | | 16b. Kind of Business/Industry
BANKING INDUSTRY | |
| 17. Father's Name (First, Middle, Last)
FRANKLIN KLEINDIENST | | | | 18. Mother's Name (First, Middle, Maiden Surname)
HARRIET HELVIN | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JAMES F. BRITTAIN, SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9118 SUDBURY ROAD, SILVER SPRING, MARYLAND 20901 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOUNT OLIVET CEMETERY | | 20c. Location - City or Town, State
WASHINGTON, D.C. | | 20d. Date
7/12/97 | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
FORT LINCOLN FUNERAL HOME
3401 BLADENSBURG RD., BRENTWOOD, MD 20722 | | | |

**Physician
/Medical
Examiner**

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. FEVER
Due to (or as a consequence of):
c. SEPSIS
Due to (or as a consequence of):
d. AMYOTROPHIC LATERAL SCLEROSIS | | | | Approximate Interval Between Onset and Death
SUDDEN
DAYS
DAYS
MONTHS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D32332 | | 29d. Date signed (Month, Day, Year)
JULY 11, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SURESH K. GUPTA, M.D., 9801 GEORGIA AVENUE, #2-20, SILVER SPRING, MD 20902 | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 11 1997 | | 32. Registrar's Signature
 | | | |

**State
Registrar**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22354

| | | | | | | | | |
|-------------------------------------|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Hilda Diana Beiber | | | | 2. Date of Death
Month Day Year
July 2 1997 | | 3. Time of Death
11:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
3111 Sedgwick Lane | | | | 4b. City, Town, or Location of Death
Bowie | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
109 20 3241 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
68 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 20, 1929 | |
| | 9. Birthplace (State or Foreign Country)
New York | | 10. Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
Prince George's | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
Bowie | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3111 Sedgwick Lane | | 10f. Zip Code
20715 | |
| | 10g. Citizen of What Country?
United States | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | |
| | 17. Father's Name (First, Middle, Last)
Lew Ringelheim | | 18. Mother's Name (First, Middle, Maiden Surname)
Gussie Ehrenreich | | 19a. Informant's Name/Relationship (Type, Print)
David Beiber Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3111 Sedgwick Lane Bowie Maryland 20715 | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Memorial Gardens | | 20c. Location - City or Town, State
Davidsonville Md. | | 21. Signature of Funeral Service Licensee
<i>Michael L. Sizer</i> | |
| | 22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc.
16000 Annapolis Rd. Bowie Md. 20715 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Metastatic Adenocarcinoma</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
<i>3 years</i> | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier:
<i>Thomas Kensing MD</i> | | 29c. License number
<i>D 08754</i> | | 29d. Date signed (Month, Day, Year)
<i>7/2/97</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Thomas Kensing MD 7525 Greenway Center Dr. Greenbelt Md.</i> | | 31. Date filed (Month, Day, Year)
<i>JUL 11 1997</i> | | 32. Registrar's Signature
<i>John A. Rindell</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22355

Amend #7, 7/10/97, BMW, Montg. Co. per F.H.

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|--|--|--|--------------------------------|---|---|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES B. CLIPPER | | | | 2. Date of Death
Month JULY Day 8 Year 1997 | | 3. Time of Death
9:55 a. | | | |
| | 4a. Facility Name (If not institution, give street and number)
20820 Slidell Road | | | | 4b. City, Town, or Location of Death
Boyd's | | 4c. County of Death
MONTGOMERY | | | |
| Funeral
Director | 5. Social Security Number
578-01-4214 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
76 75 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 14, 1920 | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Boyd's | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
20820 Slidell Road | | | | 10f. Zip Code
20841 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 44-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Concrete Finisher | | 16b. Kind of Business/Industry
Construction | | | | | |
| | 17. Father's Name (First, Middle, Last)
Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Martha Clipper | | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Bernice Clipper (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20820 Slidell Rd., Boyd's, MD 20841 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Marks Church Cem | | Date
7/14/97 | | 20c. Location - City or Town, State
Boyd's, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>George R. Snowden</i> | | | | 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 | | | | | |
| | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia
Due to (or as a consequence of):
b. Lung Cancer
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
Days
1 year | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
<i>Kenan Hudson</i> | | | | 29c. License number
D41866 | | 29d. Date signed (Month, Day, Year)
JULY 9, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
KANAN HUDHUD, MD 481 N. Frederick Ave, Suite 230, Gaithersburg, MD 20877 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 10 1997 | | | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22356

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bernard

Cohen

2. Date of Death

Month Day Year
July 7, 1997

3. Time of Death

11:10am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

088-20-8833

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 4, 1921

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10301 Grosvenor Place #804

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever In U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Pharmacist

16b. Kind of Business/Industry

Own Store

17. Father's Name (First, Middle, Last)

Harry Cohen

18. Mother's Name (First, Middle, Maiden Surname)

Rose Saltzman

19a. Informant's Name/Relationship (Type, Print)

Helene Ambrosino-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10212 Big Rock Road Silver Spring, MD 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Beth David Cemetery

Date

7/13/97

20c. Location - City or Town, State

Elmont, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction 1091 Rockville Pike
Rockville MD 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes Mellitas

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D36797

29d. Date signed (Month, Day, Year)

July 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Alan Scheff 10215 Fernwood Road Bethesda, MD 20817

31. Date filed (Month, Day, Year)

JUL 11 1997

32. Registrar's Signature

John Davidson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22357

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Jane Cook

2. Date of Death

Month Day Year
July 1, 1997

3. Time of Death

10:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

215-26-3737

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 21, 1928

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

75 Longmeadow Drive

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dental Assistant

16b. Kind of Business/Industry

Dental

17. Father's Name (First, Middle, Last)

George Payter Burton

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Palmer

19a. Informant's Name/Relationship (Type, Print)

Jane M. Baldwin/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13016 Prarie Knoll Ct., Germantown, Maryland 20874

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Montgomery Crematorium, Inc.
July 3, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Robert A. Humphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. MALIGNANT LYMPHOMA
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph M. Haggerty, M.D.

29c. License number

D32407

29d. Date signed (Month, Day, Year)

July 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph M. Haggerty, M.D. 10605 Concord Street, Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

JUL 0 8 1997

32. Registrar's Signature

Julia Davidson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22358

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|----------------------------------|---|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Estela Cruz | | | | | 2. Date of Death
Month July Day 6 Year 1997 | | 3. Time of Death
9:40 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Mariner Health - Kensington | | | | | 4b. City, Town, or Location of Death
Kensington | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
349-48-8561 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
96 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
June 30 1901 | | 9. Birthplace (State or Foreign Country)
Cuba |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
4521 East West Highway | | | | | 10f. Zip Code
20814 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Cuban | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | | 16b. Kind of Business/Industry
Education | | |
| 17. Father's Name (First, Middle, Last)
Miguel Marrero | | | | | 18. Mother's Name (First, Middle, Maiden Sumame)
Caridad Garcia | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Agustin Cruz | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4400 East West Highway, Bethesda, MD 20814 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | | Data
7/7/97 | | 20c. Location - City or Town, State
Alexandria, VA | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death

Instant

Years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
D08944 | | 29d. Date signed (Month, Day, Year)
July 7, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Martin C. Shargel, MD 3720 Farragut Avenue, Kensington, MD 20895-2110 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) July 8 1997 32. Registrar's Signature
 | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

B.

AP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22359

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Fredricka Frances Carlton | | | | 2. Date of Death
Month Day Year
June 29, 1997 | | 3. Time of Death
3:00 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Hill Haven Nursing Center | | | | 4b. City, Town, or Location of Death
Adelphi | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
579-20-8779 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 25, 1911 | |
| | 9. Birthplace (State or Foreign Country)
Iowa | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Takoma Park | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
7051 Carroll Ave. | | 10f. Zip Code
20912 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
secretary | | 16b. Kind of Business/Industry
U.S. Government | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Jacquis Carlton | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Myrta Olive Warner | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
James Fisher/cousin | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1410 Oakbluff Rd. Edgewater, MD 21037 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery 7/7/97 Arlington, VA | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Takoma Funeral Home, Inc.
254 Carroll St. NW Washington, DC 20012 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Aspiration pneumonia
Due to (or as a consequence of):
b. kyphoscoliosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | | | 29c. License number
D25009 | | 29d. Date signed (Month, Day, Year)
June 30 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Pamela Mulshine, M.D. 11251 Lockwood Dr. Silver Spring, MD 20901 | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 07 1997 | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22360

| | | | | | | | | |
|---|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DEBORAH CHAMBERLAIN | | | | 2. Date of Death
Month July Day 6 Year 1997 | | 3. Time of Death
2100 | |
| | 4a. Facility Name (If not institution, give street and number)
Howard County General Hospital | | | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
215-58-9360 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
46 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
June 17, 1951 | 9. Birthplace (State or Foreign Country)
Illinois |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Prince Georges | | 10c. City, Town or Location
Laurel | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
9206 Ispahan Loop | | | | 10f. Zip Code
20708 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Physician | | | 16b. Kind of Business/Industry
Medical | |
| 17. Father's Name (First, Middle, Last)
Theodore K. Chamberlain | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary A. Taylor | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mary A. Chamberlain | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
530 Brummel Court, NW, Washington, DC 20012 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Location - City or Town, State
7/10/97 Alexandria, VA | | |
| 21. Signature of Funeral Service Licensee
Andrew J. Cole | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Insulin overdose (self inflicted)
Due to (or as a consequence of):
b. Depression
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last
{ | | | | | | | | Approximate Interval Between Onset and Death
48 H
7204 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
July 4, 1997 | | 28b. Time of Injury
~ 9P M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
self inflicted Insulin overdose. |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
hotel | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Route 1, Laurel MD. | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29c. License number
D31473 | | 29d. Date signed (Month, Day, Year)
July 8, 1997 | | |
| 29b. Signature and title of certifier
Patricia A. Tye MD | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PATRICIA A. TYE MD 4565 Hemlocke Lane way Ellicott City MD 21042 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 09 1997 | | | | 32. Registrar's Signature
Julia Davidson-Randall | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

57-22361

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hung Choi

2. Date of Death

Month
JulyDay
9Year
1997

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

213-29-7622

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 1, 1928

9. Birthplace (State or Foreign Country)

Hong Kong

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12421 Loft Lane

10f. Zip Code

20904

10g. Citizen of What Country?

Hong Kong

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Asian

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Tailor

16b. Kind of Business/Industry

Garment

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Chau Tong

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12421 Loft Lane, Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/11/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Francis J. Collins Funeral
Home, Inc. 500 University Blvd. West
Silver Spring, MD 2090123a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)e. Colon cancer with diffuse metastases 8 years
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular Disease

History of Bleeding Duodenal Ulcer

Obstructive Uropathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TUNG PI LEE, MD 700 Buckingham Dr. Silver Spring MD 20901

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

Julia Davidson-Rendell

State
Registrar

Bm Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22362

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Charles Henry Campbell | | | | 2. Date of Death
Month July Day 4 Year 1997 | | 3. Time of Death
12:40p.m. | | |
| | 4a. Facility Name (If not Institution, give street and number)
500 Richards Lane | | | | 4b. City, Town, or Location of Death
Aberdeen | | 4c. County of Death
Harford | | |
| Funeral
Director | 5. Social Security Number
165-03-0879 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
94 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 6. Date of Birth (Month, Day, Year)
Nov. 23, 1902 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Harford | 10c. City, Town or Location
Aberdeen | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
500 Richards Lane | | | 10f. Zip Code
21001 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 Collage (1-4or 5+) 3 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrical Engineer | | | 16b. Kind of Business/Industry
Phila. Electric | | |
| | 17. Father's Name (First, Middle, Last)
William J. Campbell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Agnes Hastings | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Marjorie R. Campbell | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
500 Richards Lane, P.O. Box 643, Aberdeen, MD 21001 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Ignatius Church Cemetery | | Date
7/7/97 | | 20c. Location - City or Town, State
Hickory, Maryland | | |
| | 21. Signature of Funeral Service Licensee
Gary R. DiGiovanni | | | | 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. congestive heart failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
hypertension, diabetes, stroke, atrial fibrillation | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Hong Jun Kim | | | | 29c. License number
D-37364 | | 29d. Date signed (Month, Day, Year)
7/7/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
19 Walnut Lane, Aberdeen, Maryland | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 7 1997 | | | | 32. Registrar's Signature
John Anderson | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22363

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA R. COSTELLO

2. Date of Death

July 11 1997

3. Time of Death

1210

4a. Facility Name (If not institution, give street and number)

LORIEN NURSING HOME

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

220-12-9412

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 16, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1015 Taylor Park Road

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

John Stocktill

18. Mother's Name (First, Middle, Maiden Surname)

Grace Moore

19a. Informant's Name/Relationship (Type, Print)

Ralph H. Costello - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1015 Taylor Park Road - Sykesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cherry Hill Methodist Cemetery

Date

7-14 1997

20c. Location - City or Town, State

Cherry Hill, Maryland

21. Signature of Funeral Service Licensee

Donald S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.,
103 W. Stockton Street - Elkton, MD 21921-5521

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

b. Pneumonia

Due to (or as a consequence of):

1 week

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jacob Cherian

29c. License number

D50973

29d. Date signed (Month, Day, Year)

July 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JACOB CHERIAN Twoknoll North Dr. Columbia MD 21045

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Julia Davidson-Hendall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22364

Items:28a-f per MEO G-749 7/29/97 dh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jeffrey nmn Castanon

2. Date of Death

Month
07Day
12Year
1997

3. Time of Death

2330 hrs

4a. Facility Name (If not institution, give street and number)

205 Meadow Creek Drive

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

103-60-2509

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 27, 1964

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

120 Red Toad Road

10f. Zip Code

21901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 198613. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Benjamin Castanon

18. Mother's Name (First, Middle, Maiden Surname)

Esperanza Martinez

19a. Informant's Name/Relationship (Type, Print)

Lux M. Castanon - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 Meadow Creek Drive - Elkton, MD 21921

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

R.A. Ferris & Company

Date

7-15

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hicks Home for Funerals, P.A.
103 W. Stockton Street - Elkton, MD 21921-552123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Gunshot Wound to Head

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Immediate

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

July 12, 1997

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

self inflicted gun shot wound

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

wife's residence

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 205 Meadow Creek Dr.,
Elkton, Md.29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D15314

29d. Date signed (Month, Day, Year)

July 13, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

H Farkas, MD Union Hospital, Elkton, MD 21921

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22365

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RALPH MONRIE CRABBS

2. Date of Death

Month

Day

Year

JULY

6 1997

3. Time of Death

7:45 AM

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

705-10-4913

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 28, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2022 Charolais Court

10f. Zip Code

21048

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouseman

16b. Kind of Business/Industry

Farm

17. Father's Name (First, Middle, Last)

John Solomon Crabbs

18. Mother's Name (First, Middle, Maiden Surname)

Ida Slimmer

19a. Informant's Name/Relationship (Type, Print)

Mary Crabbs/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2022 Charolais Ct. Finksburg MD 21048

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Pipe Creek Cemetery 7/9/97

Date

20c. Location - City or Town, State

Linwood, MD

21. Signature of Funeral Service Licensee

Robert A. Myers

22. Name and Address of Facility

91 Willis Street
Myers Funeral Home Westminster MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiac Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Grammy Septicemic - Infection

Due to (or as a consequence of):

c. Anemia

Due to (or as a consequence of):

d. Non-Hodgkin Lymphoma

Approximate Interval Between Onset and Death

7d

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dean H. Griffin, M.D.

29c. License number

D04228

29d. Date signed (Month, Day, Year)

7-7-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19 Ridge Rd., Westminster MD 21157

Dean H. Griffin, M.D.

State
Registrar

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

John Andrew Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22366

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Elizabeth Chura

2. Date of Death

Month Day Year
July 5, 1997

3. Time of Death

12:38 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

033-14-0521

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 21, 1921

9. Birthplace (State or Foreign Country)

Mass.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9110 Simpson Lane

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Purchasing Agent

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

Charles H. Bellows

18. Mother's Name (First, Middle, Maiden Surname)

Eunice Foster

19a. Informant's Name/Relationship (Type, Print)

George Chura (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9110 Simpson Lane, Clinton, Maryland 20735

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mount Vernon Cemetery

Date

July 10, 1997

20c. Location - City or Town, State

Abington, Mass.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old
Alexandria Ferry Road, Clinton, Maryland 2073523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Carcinoma Of Colon

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?
☐ Yes ☒ NoHospital: ☒☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-18545

29d. Date signed (Month, Day, Year)

JULY 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Wisotsky, MD 700 Old Line Center # 207, Waldorf, Md 20602

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22367

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SALLEY BEATRICE CONNER | | | | 2. Date of Death
Month Day Year
JUNE 21, 1997 | | 3. Time of Death
4:10PM | |
| | 4a. Facility Name (If not institution, give street and number)
LIVINGSTON HEALTH CARE CENTER | | | | 4b. City, Town, or Location of Death
FORT WASHINGTON | | 4c. County of Death
PRINCE GEORGE'S | |
| Funeral
Director | 5. Social Security Number
405-36-6016 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
MAY 31, 1917 | 9. Birthplace (State or Foreign Country)
TENNESSEE |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
PRINCE GEORGE'S | | 10c. City, Town or Location
FORT WASHINGTON | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
12021 LIVINGSTON RD. | | | | 10f. Zip Code
20744 | | 10g. Citizen of What Country?
UNITED STATES | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NUTRITIONIST | | 16b. Kind of Business/Industry
D.C. SENIOR/ CITIZEN PROGRAM | | |
| 17. Father's Name (First, Middle, Last)
ALBERT BOYD | | | | 18. Mother's Name (First, Middle, Maiden Surname)
CAL DONNIE YOUNG | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MATTIE C. HAWKINS/ DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7824 KARLA LANE FORT WASHINGTON, MARYLAND 20744 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LINCOLN MEMORIAL | | Data
6/26/97 | | 20c. Location - City or Town, State
SUITLAND, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
<i>Keith A. Sings M1085</i> | | | | 22. Name and Address of Facility
ALEXANDER S. POPE FUNERAL HOMES
5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>Congestive Heart Failure</i>
Due to (or as a consequence of):
<i>Dilated Cardiomyopathy</i>
Due to (or as a consequence of):
<i>Coronary Artery Disease</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Renal Failure</i>
<i>Schistosoma</i> | | | | | | | | Approximate Interval Between Onset and Death |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
DZ4064 | | 29d. Date signed (Month, Day, Year)
7/7/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHANTHA MURTHY, M.D. 6196 OXON HILL RD., OXON HILL, MARYLAND 20745 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 08 1997 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

To Be Completed by Funeral Director

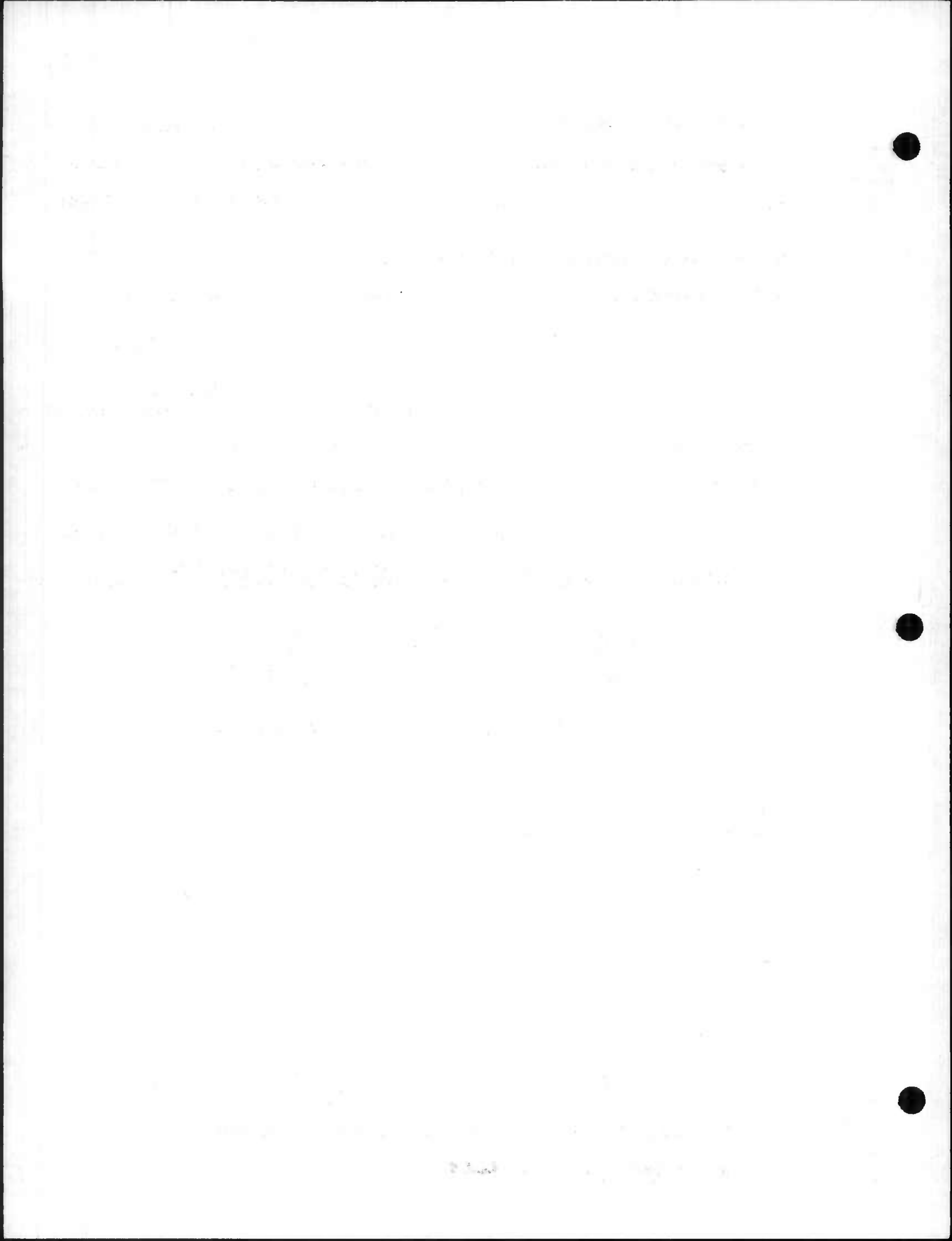
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Reg. No.

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CR

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22369

| | | | | | | | | |
|--|---|---|--|---|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE CHAMBLIS | | | | 2. Date of Death
Month JULY Day 7 Year 1997 | | 3. Time of Death
05:20 AM | |
| | 4e. Facility Name (If not Institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
578-48-4353 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
4-27-32 | 9. Birthplace (State or Foreign Country)
WASHINGTON DC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
UPPER MARLBORO | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number
13025 PAYTON DRIVE | | | | 10f. Zip Code
20774 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10TH College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
COURIER | | 16b. Kind of Business/Industry
KAISER PERMANENTE | | |
| 17. Father's Name (First, Middle, Last)
GEORGE N. CHAMBLIS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
KATIE ADKINS | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
LOU JIMMIE CHAMBLIS | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13025 PAYTON DRIVE, UPPER MARLBORO MD 20774 | | | | |
| 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HARMONY MEMORIAL PARK | | 20c. Location - City or Town, State
7-15-97 LANDOVER, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
TAYLOR'S FUNERAL HOME
1722 NORTH CAPITOL ST. NW WASH. DC | | | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. COLON CANCER
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29c. License number
D33954 | | 29d. Date signed (Month, Day, Year)
JULY 7, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 11 1997 | | | | 32. Registrar's Signature
 | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

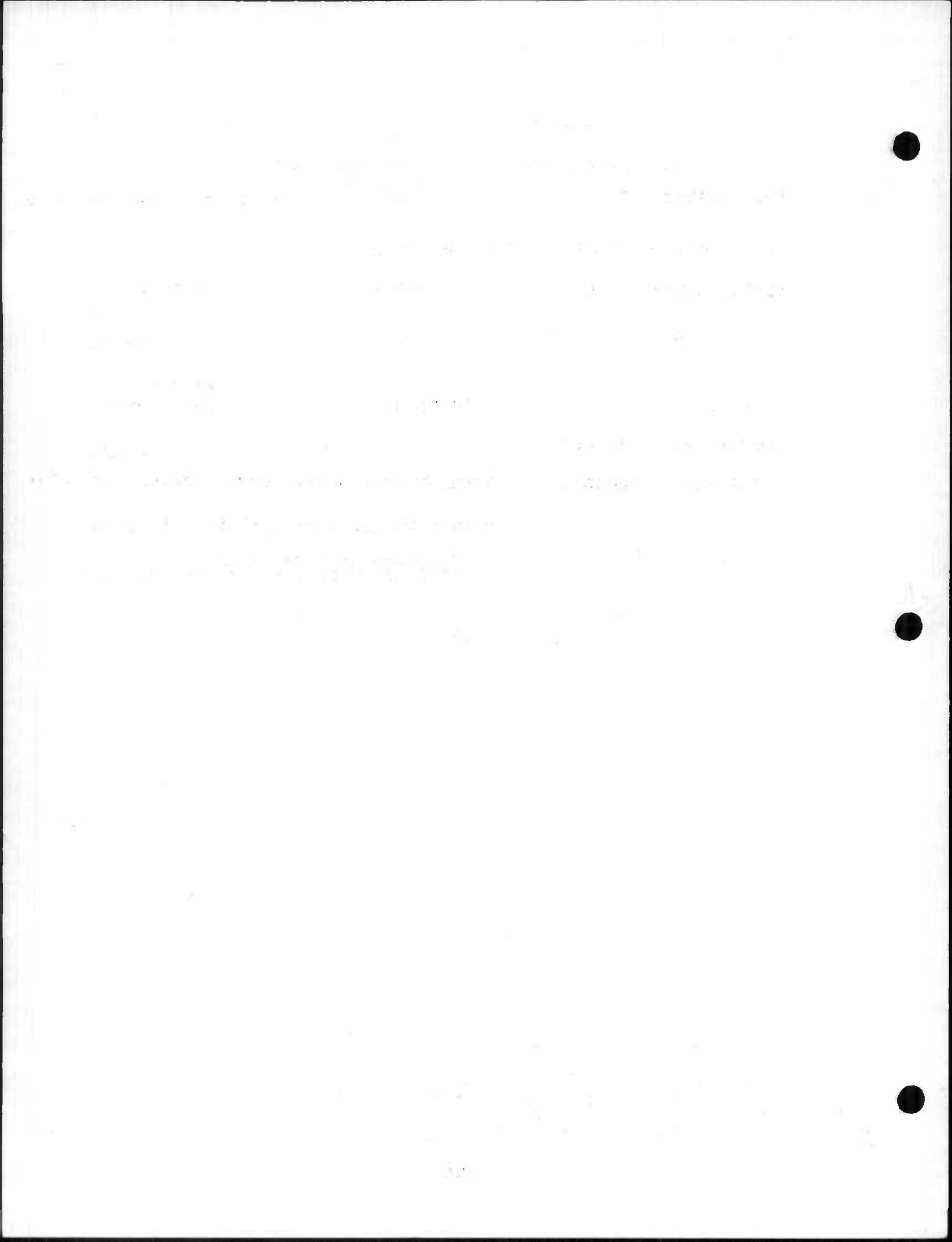
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22370

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth R. Clarke

2. Date of Death

Month Day Year
July 9, 1997

3. Time of Death

12:02 pm

4a. Facility Name (If not institution, give street and number)

Larkin Chase Nursing Home

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

214-01-3929

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 4, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's Cheverly

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5836 Dewey Street

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Montgomery Ward

17. Father's Name (First, Middle, Last)

John W. Augustine

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Barkanda

19a. Informant's Name/Relationship (Type, Print)

John E. Clarke - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5836 Dewey Street, Cheverly, Maryland 20785

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

07/10/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

One Hour

b. Metastatic Renal Cell Carcinoma

Due to (or as a consequence of):

Three Months

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D34525

29d. Date signed (Month, Day, Year)

07-09-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S.J. Rao, M.D. 4000 Mitchellville Road #220, Bowie, Maryland 20716

31. Date filed (Month, Day, Year)

JUL 11 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97 22371

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Salvino Francis Carpino | | | | 2. DATE OF DEATH
MONTH July DAY 3 YEAR 1997 | | 3. TIME OF DEATH
5:10 pm | |
| 4. SOCIAL SECURITY NUMBER
016-07-9904 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
December 21, 1919 | |
| 8. BIRTHPLACE (State or Foreign Country)
Massachusetts | | | | 9a. FACILITY NAME (If not institution, give street and number)
Villa Rosa Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Mitchellville | |
| 9c. COUNTY OF DEATH
Prince Georges | | | | 10a. STATE
Maryland | | 10b. COUNTY
Prince Georges | |
| 10c. CITY, TOWN OR LOCATION
Seabrook | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
9301 Tuckerman Street | |
| 10f. ZIP CODE
20706 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
WW II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Accountant | | 16b. KIND OF BUSINESS/INDUSTRY
Goddard Space Flight Center | |
| 17. FATHER'S NAME (First, Middle, Last)
Edgidio Carpino | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Rosa Ventura | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jane L. Carpino | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9301 Tuckerman Street, Seabrook, MD 20706 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Veterans Cemetery Maryland 7/19/97 | | 20c. LOCATION — City or Town, State
Cheltenham, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Remon/Hale Funeral Home
9013 Annapolis Road, Lanham, MD 20706 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Recurrent Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
a. Cerebral infarct
DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary Atherosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
c.
d.
Approximate interval between Onset and Death
months
years
years | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Rakish Anora, MD | | | |
| 29c. LICENSE NUMBER
D20108 | | | | 29d. DATE SIGNED (Month, Day, Year)
7/3/97 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JUL 07 1997 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22372

Amended # 4c. Per Doctor P.G.C. 7-8-97 cr

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM E. CLARK | | | | 2. Date of Death
Month Day Year
6 27 97 | | 3. Time of Death
9:30 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Pg. Mont. | |
| Funeral
Director | 5. Social Security Number
164-28-1374 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 | | 8. Date of Birth (Month, Day, Year)
Jan 20, 1936 | |
| | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| To Be Completed by Funeral Director | 10a. Street and Number
1222 Darlington Rd | | | | 10f. Zip Code
20747 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 54-56 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesman | | 16b. Kind of Business/Industry
Retail Sales | | | |
| | 17. Father's Name (First, Middle, Last)
William Clark | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alice Simpson | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mary Clark | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2100 Brook Dr. Apt 102 Forestville, Md 20747 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Quantico Nat'l | | 20c. Location - City or Town, State
7/3/97 Triangle, Va | | | |
| | 21. Signature of Funeral Service Licenses
Leander Coles | | | | 22. Name and Address of Facility
Tri-State Funeral Services, Inc.
6234 3rd St. N.W. Washington, D.C. | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. CARDIOMYOPATHY
b. DUE TO (or as a consequence of):
c. CARDIAC ARRHYTHMIAS
d. DUE TO (or as a consequence of):
e. DIABETES MELLITUS
f. DUE TO (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
Hester K. Colham MD | | | | 29c. License number
12615 | | 29d. Date signed (Month, Day, Year)
6/28/97 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
1500 Forest Glen Road Silver Spring, Md. 20910 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 08 1997 | | | | 32. Registrar's Signature
John Davidson Randall | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22373

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|--|--|---|---|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DEBORAH DALE | | | | 2. Date of Death
Month JULY Day 2 Year 1997 | | 3. Time of Death
11:10 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
375-20-0707 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 1, 1923 | | |
| | 9. Birthplace (State or Foreign Country)
Michigan | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| | 10e. Street and Number
6008 Landon Lane | | 10f. Zip Code
20817 | | 10g. Citizen of What Country?
U. S. A. | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | | |
| | 17. Father's Name (First, Middle, Last)
James W. Parry | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Blanche Amerland | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
William Dale - Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6008 Landon Lane Bethesda, MD 20817 | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Comfort Crematory | | 20c. Date
7/8/97 | | 20d. Location - City or Town, State
Alexandria, VA | | |
| | 21. Signature of Funeral Service Licensee
<i>Joseph Gawler's Sons</i> | | 22. Name and Address of Facility
Joseph Gawler's Sons
5130 WI Ave. N.W. Washington, D. C. 20016 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC BRONCHOGENIC CARCINOMA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SERIS, INFARCTED FINGER, OCCLUSIVE ARTERIOSCLEROTIC DISEASE, CEREBRAL INFARCT, LIVER AND LUNG METASTASES | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Irving Miezus, MD</i> | | 29c. License number
D26571 | | 29d. Date signed (Month, Day, Year)
7/2/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IRVING MIEZUS, MD 4930 DEL RAY AVE. BETHESDA, MD 20814 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 07 1997 | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pearl Vivian Davis

2. Date of Death

Month
July

Day

9

Year

1997

3. Time of Death

12:25

AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

232-10-5935

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 24, 1908

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10203 Day Avenue

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Pierce

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Morgan

19a. Informant's Name/Relationship (Type, Print)

Gary L. Davis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10203 Day Avenue, Silver Spring, MD 20910

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

7/9/97

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Tracy A. Shum

22. Name and Address of Facility

Francis J. Collins Funeral

Home, Inc. 500 University Blvd. West

Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

2 Years

Due to (or as a consequence of):

b. Arteriosclerotic Heart Disease

4 Years

Due to (or as a consequence of):

c. Hypothyroidism

4 Years

Due to (or as a consequence of):

d. Azotemia

1 Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Senility

Arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Tony P. Kannarkat MD

29c. License number

D-20062

29d. Date signed (Month, Day, Year)

July 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tony P. Kannarkat, M.D., 8201 16th St., Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JUL 11 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22375

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred P Donovan

2. Date of Death

Month Day Year
July 3, 1997

3. Time of Death

1:45 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health Care - Silver Spring

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

140-10-5702

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 11, 1902

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1800 Snowdrop Lane

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Practical Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

John Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Deliber

19a. Informant's Name/Relationship (Type, Print)

Richard P. Floyd / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1800 Snowdrop Lane, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph's Cemetery

Date

7/8/97

20c. Location - City or Town, State

Windsor, CT

21. Signature of Funeral Service Licensee

Ancheu Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd, West, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory failure

Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive heart failure

Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard P. Delaney

29c. License number

DO 2338

29d. Date signed (Month, Day, Year)

7/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD P. DELANEY, MD 9801 GEORGIA AVE SILVER SPRING, MD 20902

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

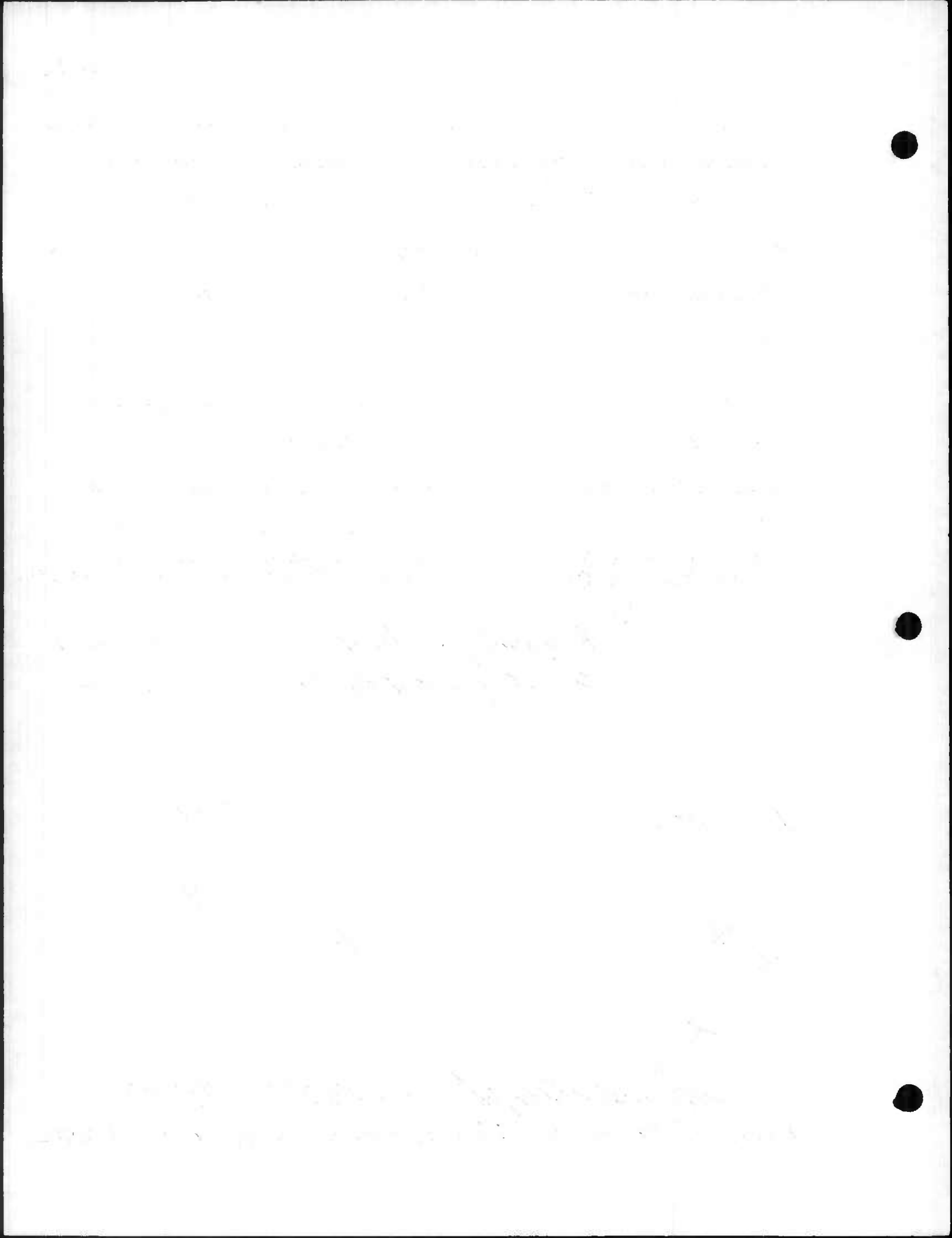
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Items: 23a part I, 27, 28a-f per ME0 G-750 8/1/97 dh Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THOMAS HUGH DORAN | | | | 2. Date of Death
Month Day Year
JUNE 23, 1997 | | 3. Time of Death
2301 PM | |
| | 4e. Facility Name (If not institution, give street and number)
4713 BOILING BROOK PARKWAY | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
555-80-4746 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
38 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 12, 1958 | |
| | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Computer Technician | | 16b. Kind of Business/Industry
Computer | | | | |
| 17. Father's Name (First, Middle, Last)
Edwin Doran | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Dressel | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Dorothy Doran/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6735 North Rockhold San Gabriel, California 91775 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Crematorium Inc. | | 20c. Location - City or Town, State
Bethesda, Maryland | | 20d. Date
June 26, 1997 | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 | | 22. M00335 | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC AND ALCOHOL INTOXICATION
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
found: 6/23/97 | | 28b. Time of Injury
found: 10:52 | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
home | | 28d. Describe how injury occurred
unknown | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
4713 Boiling Brook Pkwy. Rockville, Md. | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
JUNE 24, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 27 1997 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22377

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Thomas S. Dunn</i> | | | | 2. Date of Death
Month <i>July</i> Day <i>7</i> Year <i>97</i> | | 3. Time of Death
<i>6:45 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>2537 Glenallen Avenue #101</i> | | | | 4b. City, Town, or Location of Death
<i>Silver Spring</i> | | 4c. County of Death
<i>Montgomery</i> | |
| Funeral
Director | 5. Social Security Number
<i>577-32-7238</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>68</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>Sept. 22, 1928</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>Washington, DC</i> | | 10a. State
<i>MD</i> | | 10b. County
<i>Montgomery</i> | | 10c. City, Town or Location
<i>Silver Spring</i> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
<i>2537 Glenallen Avenue #101</i> | | 10f. Zip Code
<i>20906</i> | | 10g. Citizen of What Country?
<i>USA</i> | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>1951-53</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Automobile Salesman</i> | | 16b. Kind of Business/Industry
<i>Sales</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>James Harvey Dunn</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Nora Marie Dolan</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Nita M. March</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2 Selby Court, Poolesville, MD 20837</i> | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Metropolitan Crematory</i> | | 20c. Location - City or Town, State
<i>7/10/97 Alexandria, VA</i> | | | |
| | 21. Signature of Funeral Service Licensee
<i>Eric S. Scordo</i> | | 22. Name and Address of Facility
<i>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</i> | | | | | |
| | 23a. Pertinent, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>acute myocardial infarction</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
<i>10 mins.</i> | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>John Tauber MD</i> | | 29c. License number
<i>D08546</i> | | 29d. Date signed (Month, Day, Year)
<i>July 7 1997</i> | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>John Tauber 8218 Wisconsin Ave Bethesda MD</i> | | 31. Date filed (Month, Day, Year)
<i>JUL 09 1997</i> | | | | | |
| State Registrar | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22378

| | | | | | | | | |
|--|--|--|--|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert Russell Day | | | | 2. Date of Death
Month July Day 13 Year 1997 | | 3. Time of Death
9:02 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Genesis Eldercare Network | | | | 4b. City, Town, or Location of Death
La Plata | | 4c. County of Death
Charles | |
| Funeral
Director | 5. Social Security Number
577-32-0857 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb 15, 1929 | 9. Birthplace (State or Foreign Country)
Washington DC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Charles | | 10c. City, Town or Location
Newburg | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
13542 Forbush Road | | | | 10f. Zip Code
20664 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates
Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | 16b. Kind of Business/Industry
Ice Cream | | |
| 17. Father's Name (First, Middle, Last)
Arthur Day | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nettie Day | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Nancy J. Day/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13542 Forbush Road Newburg, MD 20664 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cem. 7/17 Cheltenham, MD | | Data | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee
Donald C. Echols M00945 | | | | 22. Name and Address of Facility
Arehart-Echols Funeral Home
P.O. Box 567 La Plata, MD 20646 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Metastatic Prostatic Cancer
Due to (or as a consequence of):
Cord. spinal compression secondary to a.
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
George Swann | | 29c. License number
D20629 | | 29d. Date signed (Month, Day, Year)
7/13/97 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GEORGE SWANN WALDORF, MD. 20603 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 15 1997 | | | | 32. Registrar's Signature
Julia Davidson-Randall | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician
/Medical
Examiner

Baltimore, Maryland 21215-0020

permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 22379

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth H. Duffy

2. Date of Death

Month Day Year
July 11, 1997

3. Time of Death

3:00 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Annapolitan

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel Co.

5. Social Security Number

147-48-9961

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

8-21-1911

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12319 Stonehaven Lane

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Frank

Heater

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Shick

19a. Informant's Name/Relationship (Type, Print)

Kathryn Petty

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2218 Hallow Lane Bowie, MD 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Elmwood Cemetery

Data

July 15

1997

20c. Location - City or Town, State

New Brunswick, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons PA Severna Park Funeral Home

495 Ritchie Hwy Severna Park MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Cardiorespiratory Arrest

Immediate

Due to (or as a consequence of):

b.

Major Depression with Psychotic Features 4 yrs

Due to (or as a consequence of):

c.

Dementia

2 years

Due to (or as a consequence of):

d.

Pneumonia

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Degenerative Arteriosclerosis

Bronchitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Paul S Rhodes MD 1667 Lynton Centre Lynton Md 21114

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8733 18

JUL 1 1957
JUL 1 1957

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Doris T. Dale

2. Date of Death

Month Day Year
June 28, 1997

3. Time of Death

1:45 pm

4a. Facility Name (If not institution, give street and number)

5101 Upshur Street

4b. City, Town, or Location of Death

Bladensburg

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-42-7992

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 30, 1913

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Bladensburg

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5101 Upshur Street

10f. Zip Code

20710

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Todd Talley

18. Mother's Name (First, Middle, Maiden Surname)

Maude Shealor

19a. Informant's Name/Relationship (Type, Print)

George Trainum - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5101 Upshur Street, Bladensburg, Maryland 20710

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

07/03/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cardiac arrest

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

034722

29d. Date signed (Month, Day, Year)

June 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vicken Poochikian, M.D. 5632 Annapolis Road, Bladensburg, Maryland 20710-2213

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22381

Reg. No.

| | | | | | | | | | | |
|---|---|-------------------------------|---|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Ruby Deer</i> | | | | | | 2. Date of Death
Month <i>7</i> Day <i>11</i> Year <i>97</i> | | 3. Time of Death
<i>7:45 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Livingston Health Care</i> | | | | | | 4b. City, Town, or Location of Death
<i>Fort Washington</i> | | 4c. County of Death
<i>Prince George</i> | |
| Funeral
Director | 5. Social Security Number
<i>577-46-8448</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>91</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>January 19, 1906</i> | | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
<i>Maryland</i> | | 10b. County
<i>Charles</i> | | 10c. City, Town or Location
<i>Indian Head</i> | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
<i>6 Maple Street</i> | | | | 10f. Zip Code
<i>20640</i> | | | 10g. Citizen of What Country?
<i>USA</i> | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | |
| 15. Decedent's Education (Specify only highest grade completed)
<i>12</i>
Elementary/Secondary (0-12) College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Budget Analyst</i> | | | 16b. Kind of Business/Industry
<i>U.S. Government</i> | | | |
| 17. Father's Name (First, Middle, Last)
<i>George Mabbott</i> | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Florence Renfro</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Betty Deer</i> | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>Same as #10</i> | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Trinity Memorial Gardens</i> | | Date
<i>July 14, 1997</i> | | 20c. Location - City or Town, State
<i>Waldorf, Maryland</i> | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> M00668 | | | | 22. Name and Address of Facility
<i>Williams Funeral Home, P.A.
4270 Hawthorne Rd., Indian Head, Md. 20640</i> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
<i>a. Arteriosclerotic cardiovascular disease</i>
Due to (or as a consequence of): <i>Myocardial infarction</i> | | | | | | | | | | <i>yes</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>b. [blank]</i>
Due to (or as a consequence of):
<i>c. [blank]</i>
Due to (or as a consequence of):
<i>d. [blank]</i> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
<i>D194B1</i> | | 29d. Date signed (Month, Day, Year)
<i>7/14/97</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Fred M Ryan MD, 1701 Lafayette Rd #203 Ft. Washington PA 20744</i> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>JUL 14 1997</i> | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22382

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE L. DOUGLAS

2. Date of Death

Month Day Year
JULY 1, 1997

3. Time of Death

9:35 PM

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH CARE

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY COUNTY

Funeral
Director

5. Social Security Number

351-10-7022

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

NOV. 4, 1915

9. Birthplace (State or Foreign Country)

KENTUCKY

Usual Residence of Decedent

10e. State

10b. County

10c. City, Town or Location

WASHINGTON, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3900 16TH STREET, N.W., APT. #206

10f. Zip Code

20011

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

EDITOR

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

GEORGE DOUGLAS

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER HOLLIDAY

19a. Informant's Name/Relationship (Type, Print)

CHARLES H. LIVINGSTON, FRIEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6521 8TH PLLACE, HYATTSVILLE, MARYLAND 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

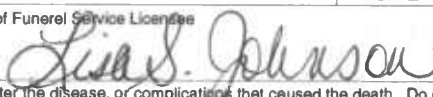
FORT LINCOLN CEMETERY

Date
7/11/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD., BRENTWOOD, MD

20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. LIVER FAILURE

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CANCER OF LIVER

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28e. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D03581

29d. Date signed (Month, Day, Year)

JULY 3, 1997

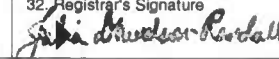
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELLIOT R. GOLDSTEIN, M.D., 9410 OLD GEORGETOWN ROAD, BETHESDA, MD 20817

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director


Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible **97-22383**
 State of Maryland / Department of Health and Mental Hygiene
 Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Nathaniel Edmonds | | 2. Date of Death
Month July Day 5 Year 1997 | | 3. Time of Death
7:10AM |
| 4a. Facility Name (If not institution, give street and number)
Collingswood Nursing & Rehab. Center | | 4b. City, Town, or Location of Death
Rockville, MD | | 4c. County of Death
Montgomery |
| 5. Social Security Number
229-14-2245 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | 8. Date of Birth (Month, Day, Year)
Oct. 9, 1922 | 9. Birthplace (State or Foreign Country)
North Carolina |
| Usual Residence of Decedent | | | | |
| 10a. State
D.C. | 10b. County | 10c. City, Town or Location
Washington, District of Columbia | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number
620 Harvard Street, N.W. | | 10f. Zip Code
20001 | | 10g. Citizen of What Country?
U.S.A. |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Custodian | | 16b. Kind of Business/Industry
Construction |
| 17. Father's Name (First, Middle, Last)
Lonnie Edmonds | | 18. Mother's Name (First, Middle, Maiden Surname)
Etta Allen | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jessie E. Boyd / sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
617-43rd St., Newport News, VA 23607 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oakland Cemetery | | 20c. Location - City or Town, State
Hampton, VA |
| 21. Signature of Funeral Service Licensee
 M1014 | | 22. Name and Address of Facility
Latney's Funeral Home
3831 Georgia Ave., N.W., D.C. 20011 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

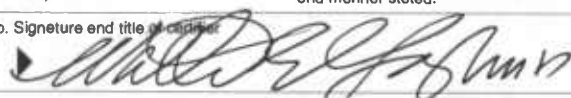
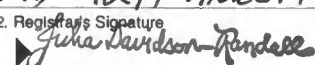
Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. RENAL FAILURE
Due to (or as a consequence of):

b. MULTIPLE STROKES
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
1 MO |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D01120 |
| | | 29d. Date signed (Month, Day, Year)
July 8, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WALTER E. GOOD MD 1299 SHOREFIELD ROAD WHEATON MD 20902 | | | | |
| 31. Date filed (Month, Day, Year)
JUL 09 1997 | | 32. Registrar's Signature
 | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22384

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BELLA COHEN EGERT | | | | 2. Date of Death
Month Day Year
JULY 4 1997 | | 3. Time of Death
3:20AM | |
| | 4e. Facility Name (If not institution, give street and number)
6050 CALIFORNIA CIRCLE, APT. #107 | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
083-07-7301 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG. 8, 1906 | |
| | 9. Birthplace (State or Foreign Country)
NEW YORK | | 10a. State
MARYLAND | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
ROCKVILLE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
6050 CALIFORNIA CIRCLE, APT. #107 | | 10f. Zip Code
20852 | | 10g. Citizen of What Country?
UNITED STATES | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last)
LOUIS COHEN | | 18. Mother's Name (First, Middle, Maiden Surname)
ANNA LUBELL | | 19e. Informant's Name/Relationship (Type, Print)
ELAINE HRUSCHKA/DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6050 CALIFORNIA CIRCLE, APT. #107, ROCKVILLE, MD 20852 | |
| To Be Completed by Physician/Medical Examiner | 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OHEV SHALOM TALMUD TORAH | | 20c. Location - City or Town, State
WASHINGTON, D.C. | | 20d. Date
7/6/97 | |
| | 21. Signature of Funeral Service Licensee
<i>Frank A. Stone</i> | | 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. ENDOMETRIAL CANCER
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
6 MONTHS | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Albert J. Steren M.D.</i> | | 29c. License number
D38682 | | 29d. Date signed (Month, Day, Year)
JULY 4, 1997 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR. ALBERT STEREN, 10215 FERNWOOD DR., #405, BETHESDA, MARYLAND 20817 | | 31. Date filed (Month, Day, Year)
JUL 07 1997 | | 32. Registrar's Signature
<i>Juana Davidson-Randall</i> | | | |
| | State Registrar | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22385

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Krikor O. Ekrek

2. Date of Death

July 6, 1997

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

11420 Georgetowne Drive

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-70-9157

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 10, 1931

9. Birthplace (State or Foreign Country)

Turkey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11420 Georgetowne Drive

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Civil Engineer

16b. Kind of Business/Industry

Engineering

17. Father's Name (First, Middle, Last)

Ohannes Ekrek

18. Mother's Name (First, Middle, Maiden Surname)

Takuhi Sinanian

19a. Informant's Name/Relationship (Type, Print)

Selva H. Ekrek/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11420 Georgetowne Drive, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

July 10, 1997

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Randy Smith

M00198

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a.

Meningioma - sleep apnea

years

Due to (or as a consequence of):

b.

arteriosclerotic cardio

years

Due to (or as a consequence of):

c.

vascular disease

Due to (or as a consequence of):

d.

atrial fibrillation

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident 6 ☐ Could not be
3 ☐ Suicide 6 ☐ determined
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frauke Westphal MD

29c. License number

D19785

29d. Date signed (Month, Day, Year)

July 7th, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frauke Westphal, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

*Frauke Westphal*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22386

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD

ESTERMAN

2. Date of Death

Month

Day

Year

3. Time of Death

4:30 PM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

032-26-8057

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

SEPT 9, 1935

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5709 MAYFAIR MANOR DRIVE

10f. Zip Code

20852

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

JEWELER

16b. Kind of Business/Industry

JEWELRY

17. Father's Name (First, Middle, Last)

LOUIS ESTERMAN

18. Mother's Name (First, Middle, Maiden Surname)

ELLA ROSENBLUM

19a. Informant's Name/Relationship (Type, Print)

MARCIA ESTERMAN/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5709 MAYFAIR MANOR DRIVE, ROCKVILLE, MARYLAND 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS. 7/6/97

Data

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. BRONCHOLITIS OBLITERANS WITH ORGANIZING PNEUMONIA 2 WKS

Due to (or as a consequence of):

b. Prior AUTOLOGOUS BONE MARROW TRANSPLANT 8 WKS

Due to (or as a consequence of):

c. Chronic Lymphocytic Leukemia 3 yrs.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending
investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D29675

29d. Date signed (Month, Day, Year)

July 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ruth Boccia, MD 9707 Monica Court Dr. Rockville, MD

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Duncan Eva

2. Date of Death

Month Day Year
July 2, 1997

3. Time of Death

8:58 AM

4a. Facility Name (If not institution, give street and number)

6448 Western Star Run

4b. City, Town, or Location of Death

Clarksville

4c. County of Death

Howard

5. Social Security Number

219-54-8044

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 19, 1914

9. Birthplace (State or Foreign Country)

South Africa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Clarksville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6448 Western Star Run

10f. Zip Code

21029

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Minister

16b. Kind of Business/Industry

Religion

17. Father's Name (First, Middle, Last)

Eugene Ingram Eva

18. Mother's Name (First, Middle, Maiden Surname)

Rose Duncan

19a. Informant's Name/Relationship (Type, Print)

Gloria Eva

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6448 Western Star Run Clarksville, Maryland 21029

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Crestlawn Memorial Gardens

Date

07/07/97

20c. Location - City or Town, State

Marriottsville,

Maryland

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Melanoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4-6 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accidental3 ☐ Suicidal4 ☐ Homicidal5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DW Eisele

29c. License number

D 36497

29d. Date signed (Month, Day, Year)

July 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David W. Eisele, M.D.

601 North Caroline

Baltimore, Maryland 21203-6402

31. Date filed (Month, Day, Year)

JUL 6 7 1997

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22388

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|--|--|--|---|--------------------------------|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Thomas Ensley</i> | | | | 2. Date of Death
Month <i>July</i> Day <i>2</i> Year <i>97</i> | | 3. Time of Death
<i>1:15 p.m.</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>307 Law Street</i> | | | | 4b. City, Town, or Location of Death
<i>Aberdeen</i> | | 4c. County of Death
<i>Harford</i> | | |
| Funeral
Director | 5. Social Security Number
<i>217-14-5278</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>74</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>Oct. 14, 1922</i> | | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | | 10b. County
<i>Harford</i> | | 10c. City, Town or Location
<i>Aberdeen</i> | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
<i>307 Law Street</i> | | | | 10f. Zip Code
<i>21001</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>1943-45</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i>0</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Car Inspector</i> | | | | 16b. Kind of Business/Industry
<i>Penn Central Railroad</i> | | |
| | 17. Father's Name (First, Middle, Last)
<i>George Ensley</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Eva Mae Tanner</i> | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Donald T. Ensley (Son)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>307 Law Street, Aberdeen, Maryland 21001</i> | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Parkwood Cemetery</i> | | Date
<i>7/10/97</i> | | 20c. Location - City or Town, State
<i>Baltimore, Maryland</i> | | |
| | 21. Signature of Funeral Service Licensee
<i>Kenneth B. Cargo</i> | | | | 22. Name and Address of Facility
<i>Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399</i> | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>Lung cancer, squamous cell</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
<i>18 mos.</i> | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Chronic Obstructive Pulmonary Disease</i> | | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>George Taler, M.D.</i> | | 29c. License number
<i>D19858</i> | | 29d. Date signed (Month, Day, Year)
<i>7/8/97</i> | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>George Taler, M.D., 29 S. Taca St. Baltimore, Md. 21201</i> | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
<i>JUL 11 1997</i> | | | | 32. Registrar's Signature
<i>John H. Randall</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22389

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LORRAINE C. FEGAN | | | | 2. Date of Death
Month JULY 2, Day 1997 Year | | 3. Time of Death
9:30 pm | |
| | 4e. Facility Name (If not institution, give street and number)
8709 Seven Locks Road | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
579-09-0622 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 19, 1919 | |
| | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
8709 Seven Locks Road | | | | 10f. Zip Code
20817 | | 10g. Citizen of What Country?
U. S. A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | |
| 17. Father's Name (First, Middle, Last)
Bernard J. Coyle | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Wyvill | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
David C. Fegan - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2249 Senseney Lane Falls Church, Virginia 22043 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cem. | | Data
7/9/97 | | 20c. Location - City or Town, State
Arlington, Virginia | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Joseph Gawler's Sons, Inc.
5130 Wisconsin Avenue N.W. WDC 20016 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction
Dua to (or as a consequence of):

b. Arteriosclerotic Heart Disease
Dua to (or as a consequence of):

c.
Dua to (or as a consequence of):

d.
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
Immediate

2 Years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
DC 11924 | | 29d. Date signed (Month, Day, Year)
July 3, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STEVEN D. LERNER, M.D. 5530 WISCONSIN AVE. BETHESDA, MD. | | | | SUITE 800 20815-4401 | | | | |
| 31. Date filed (Month, Day, Year)
JUL 07 1997 | | | | 32. Registrar's Signature
 | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

30

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22390

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Esther L. Ferguson

2. Date of Death

Month Day Year
June 22, 1997

3. Time of Death

8:00am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Manor Care Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

577-03-6097

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 27, 1916

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

Maryland Prince Georges

10b. County

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1406 East West Highway

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Isidor Leenov

18. Mother's Name (First, Middle, Maiden Surname)

Rachel Sackson

19a. Informant's Name/Relationship (Type, Print)

Daniel Leenov/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1725 Levering Pl. Bethlehem, PA 18017

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Lebanon Cemetery

Date

6/24/97

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Homes 22046

472 N. Washington St. Falls Church, VA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

b. Aspiration

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Seizures

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marilyn Kennedy

29c. License number

D35791

29d. Date signed (Month, Day, Year)

6/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Vemury 9801 Georgia Ave. Silver Spring, MD 20906

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

John Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22391

Certificate of Death


Reg. No.

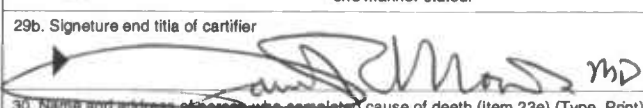

| | | | | | |
|--|---|--|--|---------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Rose Ferrigno | | 2. Date of Death
Month July Day 3 Year 1997 | | 3. Time of Death
9:45 PM |
| | 4a. Facility Name (If not institution, give street and number)
Shady Grove Adventist Nursing Center | | 4b. City, Town, or Location of Death
Rockville | | 4c. County of Death
Montgomery |
| Funeral
Director | 5. Social Security Number
579-46-9604 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
101 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
June 2, 1896 | | 9. Birthplace (State or Foreign Country)
Sicily | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
Maryland | 10b. County
Montgomery | 10c. City, Town or Location
Bethesda | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
16 Savannah Drive | | 10f. Zip Code
20817 | | 10g. Citizen of What Country?
United states |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 College (1-4 or 5+) College | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | |
| | 17. Father's Name (First, Middle, Last)
Giuseppe Barbagallo | | 18. Mother's Name (First, Middle, Maiden Surname)
Giovanna Abata | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Peter Dante Ferrigno / son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Savannah Drive, Bethesda, Maryland 20817 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery | | 20c. Location - City or Town, State
Washington, DC |
| | 21. Signature of Funeral Service Licensee
<i>Barbara Jo McMillen Lawrence</i> M00831 | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Vascular Disease
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
Years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Osteoarthritis | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | Cholelithiasis with intermittent acute pancreatitis | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28e. Describe how injury occurred | | |
| State
Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
<i>Byrl D. Johnson, M.D.</i> | | 29c. License number
D19042 | | 29d. Date signed (Month, Day, Year)
July 4, 1997 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Byrl D. Johnson, M.D. 911 Russell Avenue, Gaithersburg, MD 20879 | | | | |
| 31. Date filed (Month, Day, Year)
JUL 8 1997 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

22392

Reg. No.

| | | | | | | | | | | |
|--|---|----------------------------------|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ada Moss Fisher | | | | | | 2. Date of Death
Month Day Year
July 3 1997 | | 3. Time of Death
1200 PM | |
| | 4a. Facility Name (If not institution, give street and number)
HERMAN WILSON HEALTH CARE CENTER | | | | | | 4b. City, Town, or Location of Death
GAITHERSBURG | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
244-18-9945 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
APRIL 3, 1908 | | 9. Birthplace (State or Foreign Country)
NORTH CAROLINA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD. | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
GAITHERSBURG | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
301 RUSSELL AVE. | | | | 10f. Zip Code
20877 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALES PERSON | | | 16b. Kind of Business/Industry
J. B. IVEY | | | |
| 17. Father's Name (First, Middle, Last)
DAVID P. MOSS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
SALLIE NICHOLSON | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DOROTHY COLL/DAUGHTER | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2905 DAVENPORT ST. N.W., WASHINGTON, D.C. 20008 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SHARON MEMORIAL PARK | | | Date
7/22/97 | | 20c. Location - City or Town, State
CHARLOTTE, N.C. | | |
| 21. Signature of Funeral Service Licensee
 MO0091 | | | | | | 22. Name and Address of Facility
CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. Cerebral Arteriosclerosis</p> <p>Due to (or as a consequence of):</p> <p>b. _____</p> <p>c. _____</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>9 years</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Parkinsonism | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 MD | | | | | | 29c. License number
07231 | | 29d. Date signed (Month, Day, Year)
July 3 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
James R. Moore Jr. 207 Brookes Ave Gaithersburg MD 20877 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 09 1997 | | | | | | 32. Registrar's Signature
 | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22393

| | | | | | | | | |
|--|--|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ruth Sutton Flint | | | | 2. Date of Death
Month July Day 3 Year 1997 | | 3. Time of Death
5:55 AM | |
| | 4a. Facility Name (If not institution, give street and number)
6 Bethayres Court | | | | 4b. City, Town, or Location of Death
Derwood | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
213-56-3875 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 25, 1920 | |
| | 9. Birthplace (State or Foreign Country)
New York | | 10e. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Derwood | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
6 Bethayres Court | | 10f. Zip Code
20855 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1942/1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Registered Nurse | | 16b. Kind of Business/Industry
Nursing | | | |
| | 17. Father's Name (First, Middle, Last)
Samuel Sutton | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alvinia Daly | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Jeanne Flint/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2112 S. Quebec Street, Arlington, Virginia 22204 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Location - City or Town, State
7/3/1997 Alexandria, VA. | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
DeVol Funeral Home
10 E. Deer Park Dr., Gaithersburg, MD. 20877 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Metastatic Colon Cancer
Due to (or as a consequence of):
2 1/2 YEARS | | | | Approximate Interval Between Onset and Death
2 1/2 YEARS | | | |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D 37236 | | 29d. Date signed (Month, Day, Year)
July 3, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Carolyn B. Hendricks, M.D., 9707 Medical Center Dr., #300, Rockville, MD. 20850 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
JUL 09 1997 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22394

| | | | | | | | | | | | | |
|---|---|--|--|---|---|--|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>HARVEY</i> | | | 2. Date of Death
Month <i>July</i> Day <i>7</i> Year <i>1997</i> | | | 3. Time of Death
<i>6:58pm</i> | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Washington Adventist Hospital</i> | | | 4b. City, Town, or Location of Death
<i>Takoma Park</i> | | | 4c. County of Death
<i>Montgomery</i> | | | | | |
| Funeral
Director | 5. Social Security Number
<i>225-18-6086</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>79</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>May 11, 1918</i> | | 9. Birthplace (State or Foreign Country)
<i>Virginia</i> | | | |
| | Usual Residence of Decedent | | | 10a. State
<i>Maryland</i> | | | 10b. County
<i>Prince Georges</i> | | | 10c. City, Town or Location
<i>Adelphi</i> | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | | | 10b. County
<i>Prince Georges</i> | | | 10c. City, Town or Location
<i>Adelphi</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
<i>1504 Merrimac Drive</i> | | | 10f. Zip Code
<i>20783</i> | | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>WW 11</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>white</i> | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i> | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Electrician</i> | | | 16b. Kind of Business/Industry
<i>Northeast Electric Co.</i> | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
<i>David O. Folks</i> | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Mary Corbett</i> | | | | | | | | |
| | 19. Informant's Name/Relationship (Type, Print)
<i>Mary A. folks/Wife</i> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1504 Merrimac Dr. Adelphi, MD 20783</i> | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Cedar Hill Cemetery</i> | | | 20c. Location - City or Town, State
<i>July 11, 1997 Suitland, MD</i> | | | 20d. Date | | |
| | 21. Signature of Funeral Service Licensee
<i>George H. Folks</i> | | | 22. Name and Address of Facility
<i>Takoma Funeral Home, Inc.
254 Carroll St. NW Washington, DC 20012</i> | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. acute myocardial infarction terminal</i>
Due to (or as a consequence of):
<i>b. arteriosclerotic heart disease 10 yrs</i>
Due to (or as a consequence of):
<i>c.</i>
Due to (or as a consequence of):
<i>d.</i> | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>cardiac arrhythmia</i>
<i>congestive heart failure</i> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | | 28b. Time of Injury
<i>M</i> | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
<i>George H. Folks</i> | | | 29c. License number
<i>D12121</i> | | | 29d. Date signed (Month, Day, Year)
<i>7-8-97</i> | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>DR. GEORGE SENGSTACK</i> | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
<i>JUL 10 1997</i> | | | 32. Registrar's Signature
<i>Julia Davidson-Rendell</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22395

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|--|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elsie I. Ford | | | | 2. Date of Death
Month July Day 12 Year 1997 | | 3. Time of Death
9:00 pm. | | |
| | 4a. Facility Name (If not institution, give street and number)
7001 Floral Park Rd. | | | | 4b. City, Town, or Location of Death
Branchville | | 4c. County of Death
Prince Georges | | |
| Funeral
Director | 5. Social Security Number
578-10-1954 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
October 23, 1907 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Prince Georges | | 10c. City, Town or Location
Branchville | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
7001 Floral Park Rd | | 10f. Zip Code
20613 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Domestic | | 17. Father's Name (First, Middle, Last)
Herbert A. Young | | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Janie D. Butler | | 19a. Informant's Name/Relationship (Type, Print)
Thelma Henson Niece | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8100 Dysan Rd, Branchville MD 20613 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Bethel A.M.E July 18, 1997 Branchville MD | | 20c. Location - City or Town, State
Branchville MD | | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Adams Funeral Home, Agassaw MD 20608 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. atherosclerosis
Due to (or as a consequence of):
b. diabetes mellitus
Due to (or as a consequence of):
c. hypertension
Due to (or as a consequence of):
d. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
22574 | | |
| | 29d. Date signed (Month, Day, Year)
7/14/97 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
700 Old Line Center Suite 202 Waldorf MD 20604 | | 31. Date filed (Month, Day, Year)
JUL 16 1997 | | 32. Registrar's Signature
 | | |
| State Registrar | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22396

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James A Fouse

2. Date of Death
Month Day Year

July 12 97 1051

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

AA

5. Social Security Number

350-34-0931

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

05-09-1943

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1322 AVA ROAD

10f. Zip Code

21144

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: VIET-NAM

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NSA

16b. Kind of Business/Industry

NSA

17. Father's Name (First, Middle, Last)

JAMES AUSTIN FOUSE, SR.

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA MALLISON

19a. Informant's Name/Relationship (Type, Print)

PATRICIA ELIZABETH FOUSE (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1322 AVA ROAD, SEVERN, MARYLAND 21144

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY, INC. 7/14/97 BELTSVILLE, MD.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Director

22. Name and Address of Facility

SINGLETON FUNERAL HOME,
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cardiac Insufficiency

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

UNK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D06054

29d. Date signed (Month, Day, Year)

7/13/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William P. Jones, MD

675 America 21035

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 9054.

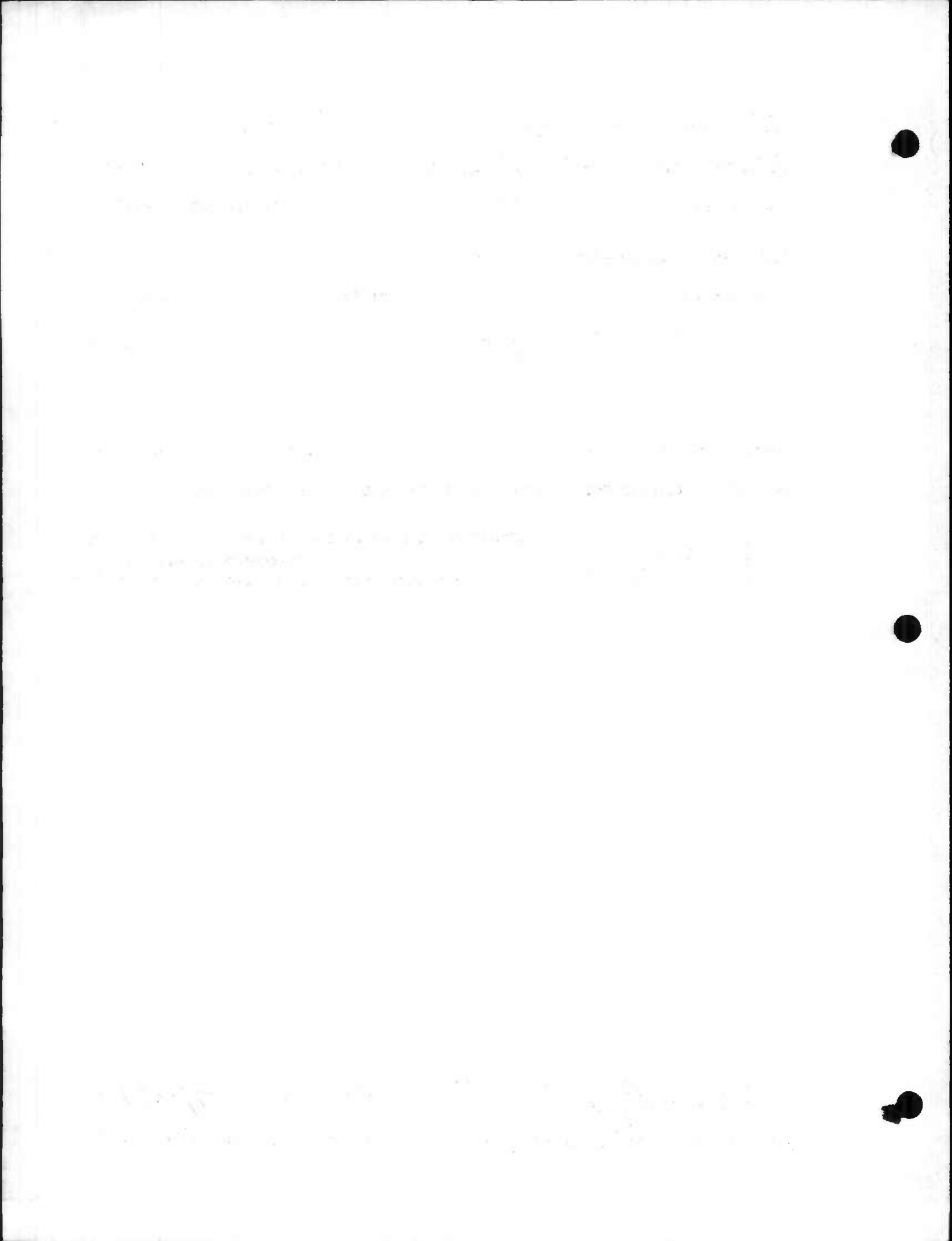
Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22397

| | | | | | | | | |
|--|---|------------------------------|---|--|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Bina Elizabeth Farver | | | | 2. Date of Death
Month JULY Day 4 Year 1997 | | 3. Time of Death
11:15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Yolanda Home | | | | 4b. City, Town, or Location of Death
Clarksville | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
212-52-1569 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 6. Date of Birth (Month, Day, Year)
Oct. 25, 1907 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Howard | 10c. City, Town or Location
Dayton | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
5004 Morning Star Drive | | | 10f. Zip Code
21036 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th | | Collage (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
own home | |
| | 17. Father's Name (First, Middle, Last)
Charles E. Wilhide | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Martha Eyler | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Faith Arrington Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5004 Morning Star Drive Dayton, MD 21036 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Taylorville Ch. Cemetery | | Date
July 7 | 20c. Location - City or Town, State
Taylorville, MD | | |
| | 21. Signature of Funeral Service Licensee
<i>Jama B Corey</i> | | 22. Name and Address of Facility
Burrier-Queen Funeral Directors, P.A.
1212 W. Old Liberty Road Winfield, MD 21784 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. PANCREATIC CANCER
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PARKINSON'S DISEASE
DIABETES MELLITUS | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Eugene Jackson, MD</i> | | 29c. License number
D25347 | | 29d. Date signed (Month, Day, Year)
JULY 4, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
EUGENE JACKSON MD 5540 TENDON RD, CLARKSVILLE, MD 21029 | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUL 07 1997 | | | | 32. Registrar's Signature
<i>John Davidson-Rodell</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22398

Amend # 7, 7/11/97, BMW, Montg. County per F.H. **Certificate of Death**

Reg. No.

| | | | | | | | | |
|--|--|--|--|---|--|---------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jean Goldsmith | | | | 2. Date of Death
Month July Day 10 Year 1997 | | 3. Time of Death
7:47 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
051-01-9209 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 15, 1914 | |
| | 9. Birthplace (State or Foreign Country)
Poland | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
9011 Alton Parkway | | 10f. Zip Code
20910 | |
| | 10g. Citizen of What Country?
United States | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Own Home | | | |
| | 17. Father's Name (First, Middle, Last)
Abraham Novack | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bayla Sofer | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Linda Rische (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9011 Alton Parkway, Silver Spring, MD. 20910 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bet Shemesh Cemetery | | 20c. Location - City or Town, State
7/11/97 Bet Shemesh, Israel | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Danzansky-Goldberg Mem. Chapels, Inc
1170 Rockville Pike, Rockville, MD. 20852 | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. BOWEL INFARCTION
Due to (or as a consequence of):
b. SEVERE ARTERIOSCLEROSIS
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death
36 HRS
YRS | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | |
| 29c. License number
D19170 | | | | 29d. Date signed (Month, Day, Year)
JULY 10, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ALAN I. KERMAIER, MD 10313 GEORGIA AVE. SILVER SPRING, MD 20902 | | | | 31. Date filed (Month, Day, Year)
JULY 11 1997 | | | | |
| 32. Registrar's Signature
<i>[Signature]</i> | | | | State Registrar | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22399

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT

N.

GREENBERG

2. Date of Death

JULY

Day

8 1997

Year

4:15 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

577-38-6823

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 1, 1915

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7012 Braeburn Place

10f. Zip Code

20817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Insurance / Agent / Broker

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Louis Greenberg

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Neuman

19a. Informant's Name/Relationship (Type, Print)

Gail F. Greenberg/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10a - 10f

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

National Memorial Park 7/10/97 Falls Church, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Pete R. House

22. Name and Address of Facility

Ives-Pearson Funeral Homes 22046

472 N. Washington St. Falls Church, VA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

CARDIAC ARREST

Due to (or as a consequence of):

b.

ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY EDEMA, RECURRENT ASPIRATION, HYPOVANAEMIA

MALNUTRITION, RECURRENT ATYPICAL PNEUMONIA,

BRONCHOLITIS OBLITERANS WITH ORGANIZING PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature of certifier

J. August, MD

29c. License number

D26571

29d. Date signed (Month, Day, Year)

JULY 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRVING MIEUS, MD 4930 DELRAY AVE BETHESDA, MD 20814

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22400

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maggie J. Gibbs.

2. Date of Death
Month Day Year

7 9 97

3. Time of Death

12-15 PM

4a. Facility Name (If not institution, give street and number)

Gladysbellman Specialty Hospital +
Nursing Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George

Funeral
Director

5. Social Security Number

251-50-7008

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
6-5-10

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1312 Gallatin Street N.W.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Family

17. Father's Name (First, Middle, Last)

Edward Jones

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Timmons

19e. Informant's Name/Relationship (Type, Print)

Eddie Lee Mims, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1312 Gallatin St.N.W., Washington, D.C. 20011

20e. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Rona Baptist Ch. Cem.

Date
7/11/97

20c. Location - City or Town, State

South
Effingham, Carolina

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service, Inc.
7400 Georgia Ave. N.W., Washington, D.C.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Due to (or as a consequence of):

Cardiopulmonary arrest.

b. Due to (or as a consequence of):

Cardiac arrhythmia.

c. Due to (or as a consequence of):

Congestive Heart failure.

d. Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter underlying
cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia, Renal insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Neelam Ashai

29c. License number

D48213

29d. Date signed (Month, Day, Year)

7-10-97.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neelam Ashai, M.D., 3001 Hospital Drive, Cheverly, Maryland

31. Date filed (Month, Day, Year)

JUL 11 1997

Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

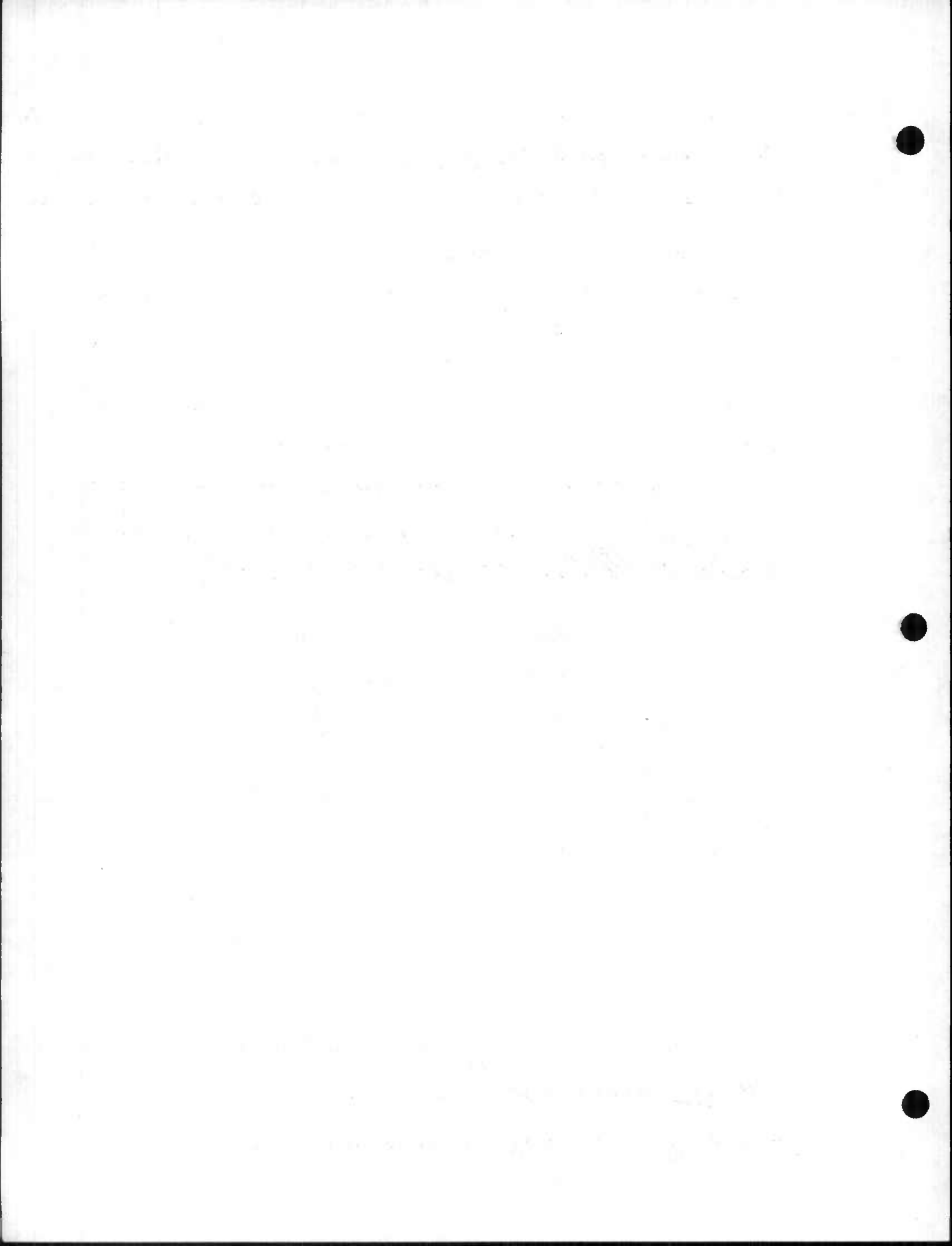
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22401

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles V. Gibson

2. Date of Death

Month Day Year
July 7, 1997

3. Time of Death

12:15 a.m.

4a. Facility Name (If not institution, give street and number)

Fernwood, Manor Care

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

577-10-4766

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 16, 1907

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D. C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4404 Yuma Street N. W.

10f. Zip Code

20016

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No WW II

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Military Officer

16b. Kind of Business/Industry

U. S. Army

17. Father's Name (First, Middle, Last)

Richard Gibson

18. Mother's Name (First, Middle, Maiden Surname)

Eliza Jane Hartil

19a. Informant's Name/Relationship (Type, Print)

Orville S. Gibson - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4404 Yuma St. N. W. Washington, D. C. 20016

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Natl. Cemetery

Date

7/14/97

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Joseph A. P.

22. Name and Address of Facility Joseph Gawler's Sons, Inc.

5130 Wisconsin Ave. NW WDC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition, dehydration, hypertension

and congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Chablan

29c. License number

D 42518

29d. Date signed (Month, Day, Year)

July 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gui Chablani, M. D. 11119 Rockville Pike #316 Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

July 11 1997

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

AM
WILLIAM
GIVEN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22402

| | | | | | | | | |
|--|--|--|---|---|--|------------------------------------|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>William H. Given</i> | | | | 2. Date of Death
Month <i>JULY</i> Day <i>09</i> Year <i>1997</i> | | 3. Time of Death
<i>09:55 A</i> | |
| | 4e. Facility Name (If not institution, give street and number)
<i>14 CROUCH CHAPEL RD.</i> | | | | 4b. City, Town, or Location of Death
<i>Elkton</i> | | 4c. County of Death
<i>CECIL</i> | |
| Funeral
Director | 5. Social Security Number
<i>216-20-8409</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>71</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
<i>12-16-25</i> | 9. Birthplace (State or Foreign Country)
<i>Delaware</i> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | | 10b. County
<i>Cecil</i> | | 10c. City, Town or Location
<i>Elkton</i> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
<i>14 Crouch Chapel Rd</i> | | | | 10f. Zip Code
<i>21921</i> | | 10g. Citizen of What Country?
<i>USA</i> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>WW II</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Factory Worker</i> | | 16b. Kind of Business/Industry
<i>Auto Industry</i> | |
| | 17. Father's Name (First, Middle, Last)
<i>Robert Given</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Marion Meisel Given</i> | | | |
| Physician
/Medical
Examiner | 19e. Informant's Name/Relationship (Type, Print)
<i>Emily Given/Sister</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>152 Basil Avenue Chesapeake City, MD 21915</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Bethel Cemetery</i> | | 20c. Location - City or Town, State
<i>July 12, 1997 Chesapeake City, MD</i> | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
<i>R. T. Foard Funeral Home
P.O. Box 27 Chesapeake City, MD 21915</i> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Contact Gunshot Wound of Right Temple</i>
Due to (or as a consequence of):

<i>b.</i> Due to (or as a consequence of):

<i>c.</i> Due to (or as a consequence of):

<i>d.</i> | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Depression</i> | | | | 24a. Was an autopsy performed?
<i>partial</i>
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
<i>Found 7-9-97</i> | | 28b. Time of Injury
<i>945 A M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred
<i>self-inflicted gunshot</i> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
<i>Home Elkton, Md</i> | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>Dennis J. Chute, MD</i> | | 29c. License number
<i>OCME</i> | | |
| 29d. Date signed (Month, Day, Year)
<i>JULY 10, 1997</i> | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>JUL 11 1997</i> | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

19W
10
+1-VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22403

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOY E. GWILLIM

2. Date of Death

Month
July

Day

7

Year

1997

3. Time of Death

2200

4a. Facility Name (If not institution, give street and number)

MedPointe

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

416-76-6389

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9-6-1951

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Earleville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

71 Long Point Blvd.

10f. Zip Code

21919

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Reporter

16b. Kind of Business/Industry

Journalism

17. Father's Name (First, Middle, Last)

Thomas Prise Gwillim, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Edith Lucile Higgins

19a. Informant's Name/Relationship (Type, Print)

Jane Henry

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Cherry Grove Rd., Earleville, MD. 21919

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Capitol Crematory

Date

7/8/97

20c. Location - City or Town, State

Dover, DE.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANIELS & HUTCHISON FUNERAL HOMES

212 N. Broad St., Middletown, DE. 19709

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

Metastatic Cancer of Breast

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

H35860

29d. Date signed (Month, Day, Year)

7-8-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Irving M. Berkowitz, DO. 501 W 14th St., Wilmington, DE. 19801

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

Julia Anderson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4-2-42

H32800

Handwritten notes, possibly "H32800" and "4-2-42" repeated.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Lynn Geffen

2. Date of Death

Month Day Year
July 9, 1997

3. Time of Death

6:30 PM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

220-66-8200

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

30

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
May 25, 1967

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State
Maryland P.G.

10b. County

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

9411 Eugina Park Street

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Paying & Receivables

16b. Kind of Business/Industry

Defense Subcontractor

17. Father's Name (First, Middle, Last)

Bernard Geffen

18. Mother's Name (First, Middle, Maiden Surname)

Mollie Wade

19a. Informant's Name/Relationship (Type, Print)

Mollie Geffen (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

761 Horseman Drive, Port Orange, FL 32127

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

July 14, 1997

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Gastrointestinal Hemorrhage*

Due to (or as a consequence of):

b. *Liver failure*

Due to (or as a consequence of):

c. *Alcohol Abuse*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D45630

29d. Date signed (Month, Day, Year)

7/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arnulfo Bonavente, MD 6409 SW Crain Hwy, Upper Marlboro, Md 20772

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

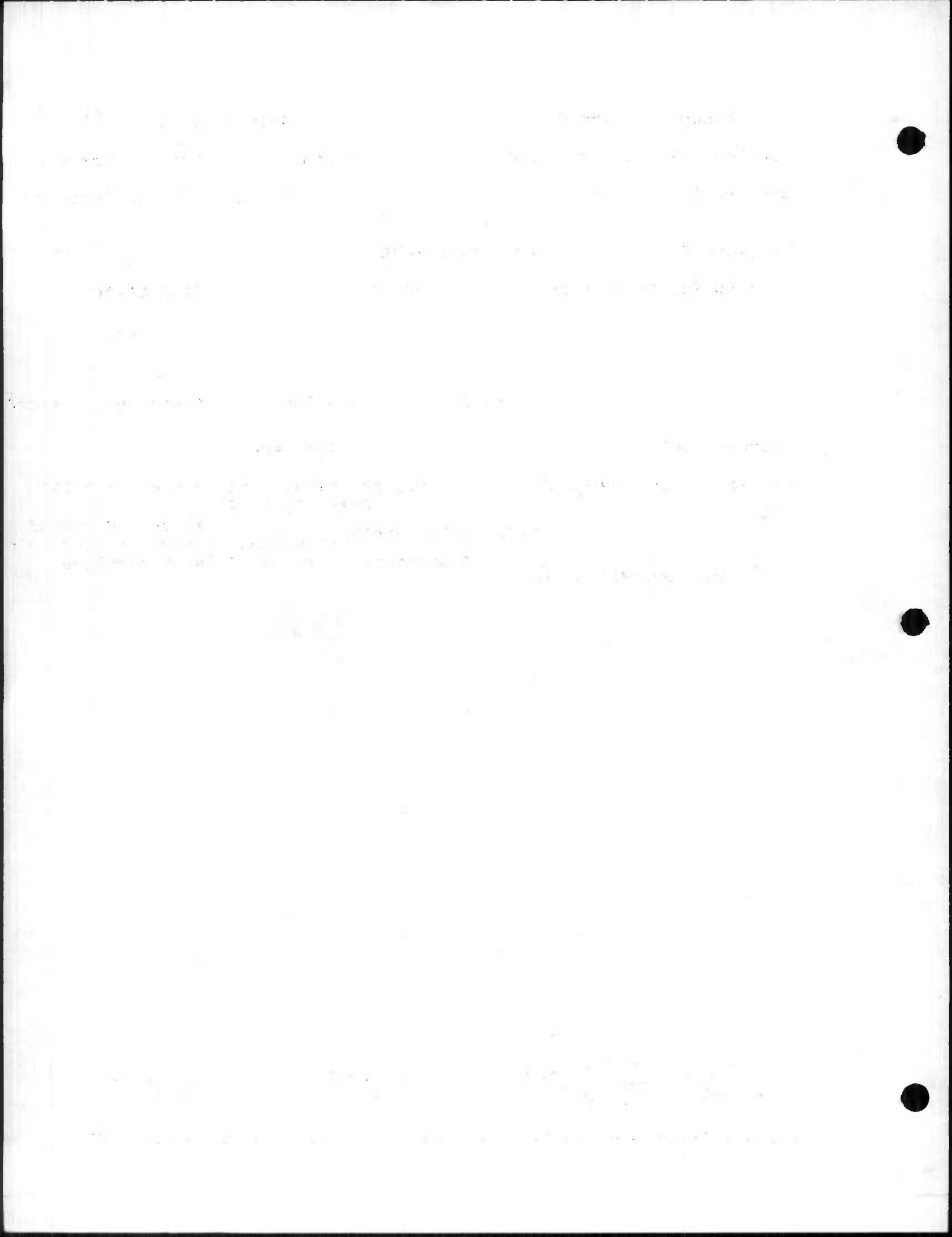
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22405

| | | | | | | | | |
|--|--|-------------------------------|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Raymond Grosskurth | | | | 2. Date of Death
Month July Day 12 Year 1997 | | 3. Time of Death
7:50AM | |
| | 4a. Facility Name (If not institution, give street and number)
8609 Vistula Drive | | | | 4b. City, Town, or Location of Death
Ft. Washington | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
578-30-1924 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 2, 1927 | |
| | 9. Birthplace (State or Foreign Country)
Washington DC | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Fort Washington | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
8609 Vistula Drive | | 10f. Zip Code
20744 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1950-
If Yes, Give Year or Dates: 1954 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Aircraft Instructor | | 16b. Kind of Business/Industry
U.S.A.F. | | 17. Father's Name (First, Middle, Last)
Carl William Grosskurth | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Florine Christine White | | 19a. Informant's Name/Relationship (Type, Print)
Agnes Grosskurth (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8609 Vistula Drive Ft. Washington MD 20744 | | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee Crematory | | 20c. Location - City or Town, State
Clinton, Maryland | | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Lee Funeral Home, Inc.
6633 Old Alexandria Ferry Rd Clinton, MD 20735 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Lung Cancer
Due to (or as a consequence of):
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____ | | Approximate Interval Between Onset and Death
9 months | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| State Registrar | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier
 | | 29c. License number
D30484 | | 29d. Date signed (Month, Day, Year)
7/12/97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles A. Umosella, M.D. 4333 Old Branch Ave. Marlow Hgts. Md. 20748 | |
| 31. Date filed (Month, Day, Year)
JUL 15 1997 | | 32. Registrar's Signature
 | | | | | | |

Amended Item #9b & 9c, 7/9/97
per F.D., Carroll Co., w.j.l.

97 22406

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|------------------------------------|---|---|---|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Willie Steddings</i> | | | 2. DATE OF DEATH
MONTH DAY YEAR
<i>7 2 97</i> | | 3. TIME OF DEATH
<i>12 NOON</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER
<i>214-28-4823</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>71</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>03-19-26</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>Virginia</i> | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Pleasant View Nursing Home</i> | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Mt. Airy</i> | | | 9c. COUNTY OF DEATH
<i>Carroll</i> | | | | |
| 10a. STATE
<i>MD</i> | | 10b. COUNTY
<i>Carroll</i> | | 10c. CITY, TOWN OR LOCATION
<i>Mt. Airy</i> | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
<i>4101 Baltimore Nat. Pike</i>
<i>Pleasant View Nursing Home</i> | | | | 10f. ZIP CODE
<i>21771</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>Black</i> | | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i></i> | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Laborer</i> | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Phone Company</i> | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>unknown</i> | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>unknown</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Pleasant View Nursing Home</i> | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4101 Baltimore Nat. Pk. Mt Airy MD 21771</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Springfield Cemetery 7/3/97</i> | | 20c. LOCATION — City or Town, State
<i>Sykesville MD</i> | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Harry W. Haight</i> | | | 22. NAME AND ADDRESS OF FACILITY
<i>Haight Funeral Home</i>
<i>P.O. Box 195 Sykesville MD 21784</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CEREBROVASCULAR ACCIDENT</i>
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
<i>ATHEROSCLEROTIC HEART DISEASE</i>
<i>DEMENTIA</i>
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | Approximate Interval Between Onset and Death
<i>1 DAY</i> | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>ATHEROSCLEROTIC HEART DISEASE</i>
<i>DEMENTIA</i>
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | 29c. LICENSE NUMBER
<i>D43091</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>7-3-97</i> | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>SARAH ZANDI 801 TOLL HOUSE AVE, FREDERICK, MD 21701</i> | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>JUL 09 1997</i> | | 32. REGISTRAR'S SIGNATURE
<i>Johi Anderson-Randall</i> | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WILLIAM GARNEY
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22407

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Henry Garner IV

2. Date of Death
Month Day Year

JULY 05 1997

3. Time of Death
3:38 A

4a. Facility Name (If not institution, give street and number)

MARYLAND SHOCK TRAUMA

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

219-88-1986

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

28

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Sept. 5, 1968

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1768 Carriage Way

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

land scaper

16b. Kind of Business/Industry

lawn care

17. Father's Name (First, Middle, Last)

William H. Garner III

18. Mother's Name (First, Middle, Maiden Surname)

Jessica Collins

19a. Informant's Name/Relationship (Type, Print)

Jessica Collins Garner/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1768 Carriage Way, Frederick, MD 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. James Cemetery

Date

7/9

20c. Location - City or Town, State

New Windsor, MD

21. Signature of Funeral Service Licensee

Doris L. Brothers

22. Name and Address of Facility

Hartzler Funeral Home
Union Bridge, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

7-5-97

28b. Time of
Injury

02:20 M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Roadway

28d. Describe how injury occurred

Driver
auto - auto collision28f. Location (Street and Number or Rural Route Number,
City or Town, State)

Harney Rd

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David R. Fowler

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 05, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R. Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22408

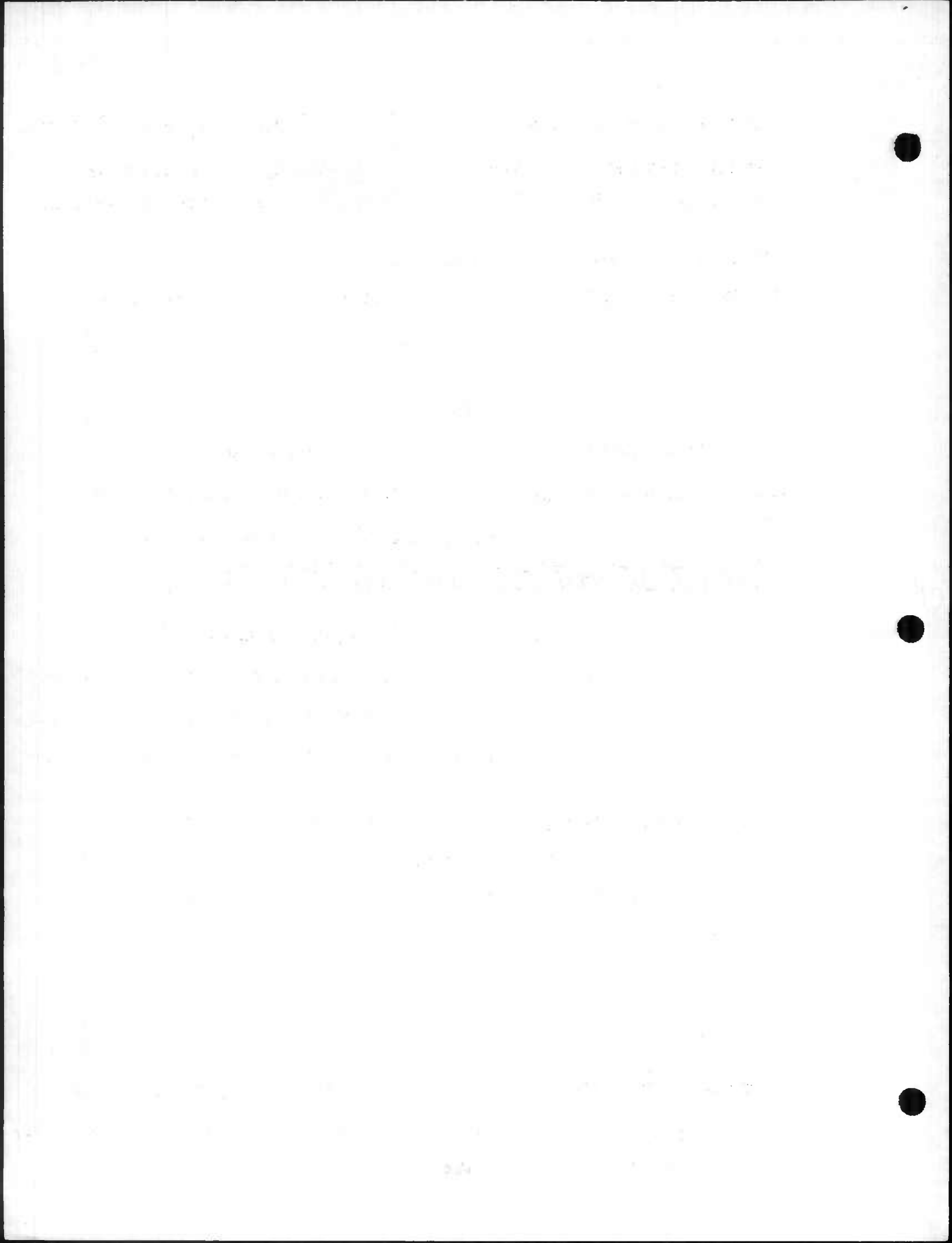
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SHIRLEY ELIZABETH GARDNER | | | | 2. Date of Death
Month July Day 2 Year 1997 | | 3. Time of Death
2:34 AM | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
577-38-0939 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 20, 1926 | |
| | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | 10a. State
District of Columbia | | 10b. County
Washington | | 10c. City, Town or Location
Washington | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
924 49th Street, N. E. | | 10f. Zip Code
20019 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerk | | 16b. Kind of Business/Industry
Government | | 17. Father's Name (First, Middle, Last)
Otis Unknown | |
| | 18. Mother's Name (First, Middle, Maiden Summa)
Helen White | | 19a. Intorment's Name/Relationship (Type, Print)
Raymond A. Gardner - Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
924 49th Street, N.E., Washington, D. C. 20019 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery | | 20c. Date
7/8/97 | | 20d. Location - City or Town, State
Washington, D. C. | | 21. Signature of Funeral Service Licensee
John T. Stewart III | |
| | 22. Name and Address of Facility
STEWART FUNERAL HOME, Inc.
4001 Benning Road, N. E., Washington, D. C. | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CARDIAC SINUS NODE ARREST | | 23b. Approximate interval between Onset and Death
5 Mins | | 23c. Due to (or as a consequence of):
DIFFUSE INTRAVASCULAR THROMBOSIS 24 HRS | |
| To Be Completed by Physician/Medical Examiner | 23d. Due to (or as a consequence of):
DISSEMINATED INTRAVASCULAR COAGULATION 2 Days | | 23e. Due to (or as a consequence of):
ADULT RESPIRATORY DISTRESS SYNDROME 7 DAYS | | 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
BILATERAL LUNG INFILTRATES
CONGESTIVE HEART FAILURE
RESPIRATORY FAILURE | | 23g. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 23h. Were an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23i. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 26. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 27. Date of Injury (Month, Day, Year)
July 8, 1997 | | 27b. Time of Injury
M | | 27c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 27d. Describe how injury occurred | | 27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 27f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| State Registrar | 28b. Signature and title of certifier
David A. Gootz | | 28c. License number
D28195 | | 28d. Date signed (Month, Day, Year)
07-02-97 | | 29. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID A. GOOTZ, MD. 12164 Central Ave. #200 Mitchellville MD 20721 | |
| | 30. Date filed (Month, Day, Year)
JUL 09 1997 | | 31. Registrar's Signature
John A. Harkins | | 32. Registrar's Title
Registrar | | 33. Registrar's Office
State Registrar | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22409

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DESSEY LANDRUM HARRISON

2. Date of Death

Month
JULYDay
2,Year
1997

3. Time of Death

1:15AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

263 CONGRESSIONAL LN. #320

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

252-50-1753

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

FEB. 26, 1936

9. Birthplace (State or Foreign Country)

GA.

Usual Residence of Decedent

10a. State

GA.

10b. County

RICHMOND

10c. City, Town or Location

AUGUSTA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1208 COLONY PLACE DR.

10f. Zip Code

30907

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

PRIVATE CO.

17. Father's Name (First, Middle, Last)

JAMES C. HARRISON

18. Mother's Name (First, Middle, Maiden Surname)

LAURA B. KUHLE

19a. Informant's Name/Relationship (Type, Print)

DORIS HARRISON/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

7/7/97

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service licensee

W. W. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOME, P.A., RIVERDALE, MD. 20737

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. NON HODGKIN'S LYMPHOMA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 yr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Oscar Breathnach

29c. License number

RES-000

FEDERAL DOCTOR

29d. Date signed (Month, Day, Year)

7/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSCAR BREATHNACH 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

State

Registrar

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97 22410

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Emma Lettie Haugh | | | | 2. DATE OF DEATH
MONTH DAY YEAR
July 6 1997 | | 3. TIME OF DEATH
1:09 PM | |
| 4. SOCIAL SECURITY NUMBER
218-20-2356 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Dec. 28, 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number)
913 Hollywood Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Silver Spring | | 9c. COUNTY OF DEATH
Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Montgomery | | 10c. CITY, TOWN OR LOCATION
Silver Spring | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
913 Hollywood Avenue | | | | 10f. ZIP CODE
20904 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — if yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Draftsman | | 16b. KIND OF BUSINESS/INDUSTRY
FHA | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Karl Braun | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Frieda Blanc | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jeannette M. Warren/Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3330 N. Leisure World Blvd., Silver Spring, MD 20906 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 7/9/97 | | 20c. LOCATION — City or Town, State
Silver Spring, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Louis J. Holland</i> | | | | 22. NAME AND ADDRESS OF FACILITY
Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Infarction</i>
DUE TO (OR AS A CONSEQUENCE OF):
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval between Onset and Death
8 hours |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D14057 | | 29d. DATE SIGNED (Month, Day, Year)
July 6, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Lewis Kellert, M.D. 4000 Olney Laytonsville Rd. Olney, Md. 20832 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JUL 10 1997 | | | | 32. REGISTRAR'S SIGNATURE
<i>Jana Davidson-Rendell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22411

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|--|--|--|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WALTER T. HOLLAND, SR. | | | | | | 2. Date of Death
Month Day Year
July 7, 1997 | | 3. Time of Death
11:51 P. | | | |
| | 4a. Facility Name (If not institution, give street and number)
Howard County General Hospital | | | | | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
HOWARD | | | |
| Funeral
Director | 5. Social Security Number
218-07-7991 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 26, 1912 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Howard | | 10c. City, Town or Location
Columbia | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
7505 Oakland Mills Road | | | | 10f. Zip Code
21046 | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 44-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | | 16b. Kind of Business/Industry
Construction | | | | |
| | 17. Father's Name (First, Middle, Last)
John Holland | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Matthews | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Janis Addison (Daughter) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
208 W. Deer Park Rd., Gaithersburg, MD 20877 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem. Park | | Date
7/12/97 | | 20c. Location - City or Town, State
Elkridge, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>George R. Snowden</i> | | | | 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 | | | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CHRONIC LYMPHOCYTIC LEUKEMIA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
6 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PROSTATE CARCINOMA ; HYPERTENSIVE HEART DISEASE ; ATRIAL FLUTTER | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| State Registrar | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Colleen MD</i> | | 29c. License number
D 22755 | | 29d. Date signed (Month, Day, Year)
7. 8. 97 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
7350 VAN DUSEN RD # 260 LAUREL MD 20707 | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 10 1997 | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22412

Certificate of Death

Reg. No.

| | | | | | | | | |
|-------------------------------------|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Fannie E. Huff | | | | 2. Date of Death
Month July Day 3, Year 1997 | | 3. Time of Death
5:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Fairland Nursing & Rehabilitation | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
579 24 5530 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 25, 1904 | |
| | 9. Birthplace (State or Foreign Country)
North Carolina | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
2101 Fairland Road | | | | 10f. Zip Code
20904 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cook | | 16b. Kind of Business/Industry
Private Homes | | | |
| | 17. Father's Name (First, Middle, Last)
Unavailable | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Unavailable | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Roberta Hopkins (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 Forsythia Court, Burtonsville, MD. 20866 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | Data
7/9/97 | | 20c. Location - City or Town, State
Silver Spring, MD. | |
| | 21. Signature of Funeral Service Licensee
<i>Harvey E. Huff</i> | | 22. Name and Address of Facility
McGuire Funeral Service Inc.
7400 Georgia Ave., N.W., Washington, D.C. 20012 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Dua to (or as a consequence of):
b. Hypertensive Cardiovascular Disease
Dua to (or as a consequence of):
c. Atherosclerotic Cardiovascular Disease
Dua to (or as a consequence of):
d. Cerebrovascular Disease | | | | | | | |
| | Approximate Interval Between Onset and Death
8 Hours
Years
Years
Years | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Peripheral Vascular Disease
Pacemaker - Ventricular Arrhythmia
Peg Placement | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Patricia S. Armstrong</i> | | | | 29c. License number
D42618 | | 29d. Date signed (Month, Day, Year)
July 3, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Patricia S. Armstrong, M.D., 321 Flannery Lane, Silver Spring, Maryland 20904 | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUL 08 1997 | | | | 32. Registrar's Signature
<i>John Davidson-Rodella</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22413**
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIE B. HUGHES | | | | 2. Date of Death
Month JULY Day 8 , Year 1997 | | 3. Time of Death
6:55 P. | |
| | 4a. Facility Name (If not institution, give street and number)
1003 Fairland Road | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
214-16-7576 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 14, 1914 | |
| | 9. Birthplace (State or Foreign County)
N. Carolina | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
1003 Fairland Road | | 10f. Zip Code
20904 | | |
| 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Gardner | | 16b. Kind of Business/Industry
Montg. College | | |
| 17. Father's Name (First, Middle, Last)
Bonnie Hughes | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lessie Malone | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Cynthia Hughes (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1003 Fairland Rd., Silver Spring, MD 20904 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Mem. Park | | Date
7/12/97 | | 20c. Location - City or Town, State
Rockville, MD | | |
| 21. Signature of Funeral Service Licensee
<i>Carroll D. Mahoney</i> | | 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Carcinoma of Lung
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
2 yrs | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Carroll D. Mahoney M.D.</i> | | 29c. License number
D0477T | | 29d. Date signed (Month, Day, Year)
7-9-97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Carroll D. Mahoney 10301 Georgia Ave. Silver Spring, Md | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 10 1997 | | 32. Registrar's Signature
<i>J. Davidson-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22414

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES Edward HUGHEY

2. Date of Death

Month
JULY

Day

1

Year

1997

3. Time of Death

18:20p

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

465-54-1896

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Feb. 21, 1938

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7707 - 12th Street N.W.

10f. Zip Code

20012

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1955-58

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

B.C. Andrews

18. Mother's Name (First, Middle, Maiden Summa)

Linnie Lou Hughey

19a. Informant's Name/Relationship (Type, Print)

Wanda L. Hughey, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7707 - 12th St. N.W., Washington, D.C. 20012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

7/7/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service, Inc.

7400 Georgia Ave. N.W., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

a.

liver failure

Due to (or as a consequence of):

2 weeks

b.

liver cancer

Due to (or as a consequence of):

2 months

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending2 ☐ Accident investigation3 ☐ Suicide 6 ☐ Could not be4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

29e. Signature and title of certifier

29f. License number

29g. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DORRY SCHEE, MD, JOHNS HOPKINS, TOWER 100, BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

John Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

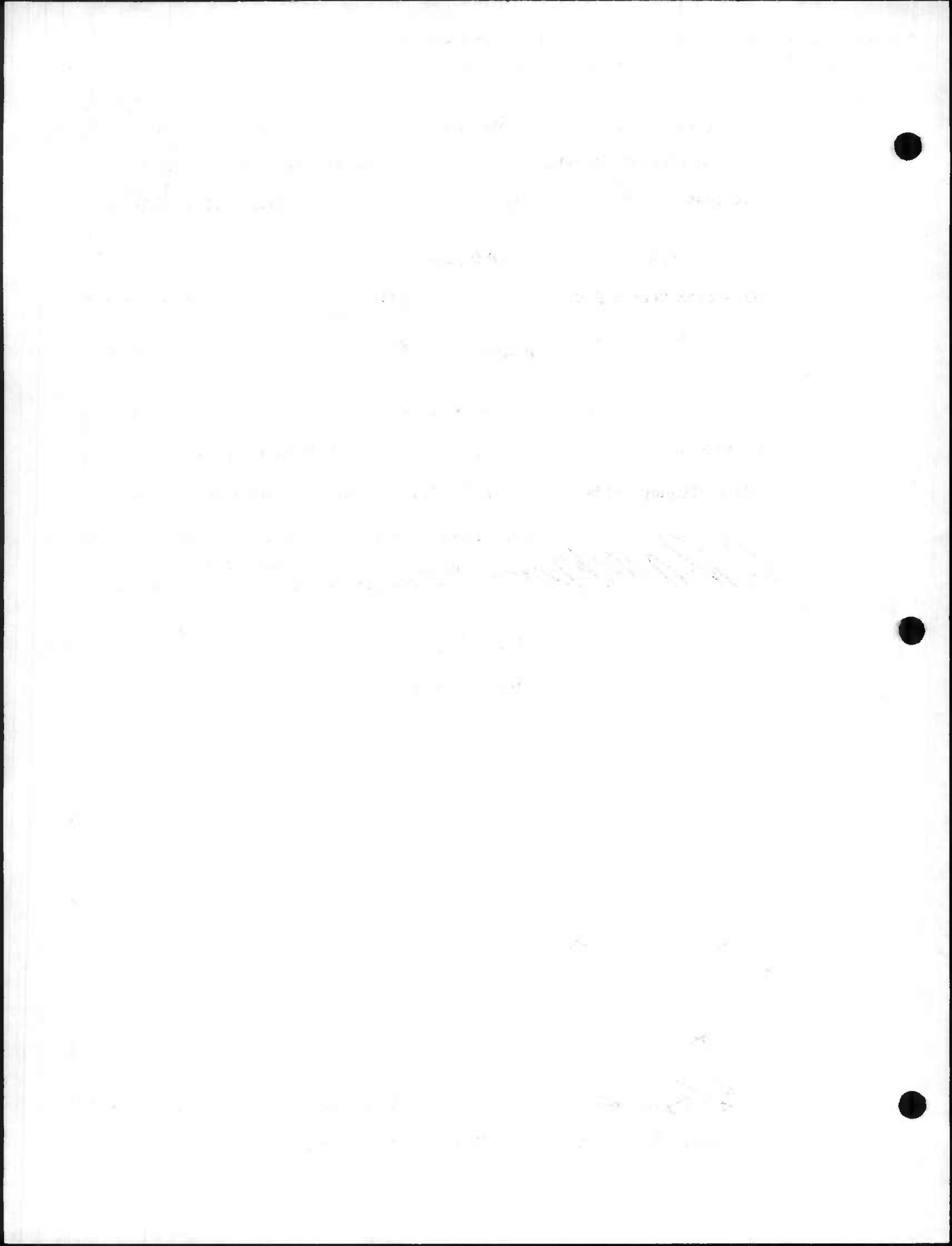
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97-22415

| | | | | | | | | | |
|---|--|---|--|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARIE E. HAYWARD | | | | 2. Date of Death
Month July Day 10 Year 1997 | | 3. Time of Death
5:30 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Lorien Nursing + Convalescent Home Columbia | | | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
Howard | | |
| Funeral
Director | 5. Social Security Number
185-28-0544 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 15, 1905 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Baltimore City | | 10c. City, Town or Location
Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
1932 Greenhaven Drive | | 10f. Zip Code
21209 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Ssecondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | 17. Father's Name (First, Middle, Last)
Albertus V. Beakes | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Keller | |
| 19a. Informant's Name/Relationship (Type, Print)
Patricia H. Murphy-daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1932 Greenhaven Dr., Baltimore, MD 21209 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Slateville cemetery | | 20c. Location - City or Town, State
Delta, PA | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
Harkins F.H. Inc., Delta, PA 17314 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immadiata Causa (Final disease or condition resulting in death)
a. Bilateral Pneumonia
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
48 hours | | | |
| Part II. Other egnificant conditions contributing to death but not resulting in the underlying causa given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of causa of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicida <input type="checkbox"/> Homicida | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury et Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Phyeclan: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated.
<input type="checkbox"/> Medcel Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceusa(s) and mannar stated. | | 29b. Signatura end titla of certifier
William Flowers m.d. | | 29c. Licansa number
D20789 | | 29d. Data signed (Month, Day, Year)
July 10, 1997 | | | |
| 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)
William Flowers m.d. 1.055 Little Patuxent Columbia | | 31. Data filed (Month, Day, Year)
JUL 11 1997 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

The first part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation $f(x) = \int_0^x f(t) dt$. It is shown that $f(x)$ is a continuous function and that it satisfies the differential equation $f'(x) = f(x)$. The solution of this equation is $f(x) = Ce^{x^2/2}$, where C is a constant. The value of C is determined by the initial condition $f(0) = 1$, which gives $C = 1$. Therefore, the function $f(x)$ is $f(x) = e^{x^2/2}$.

In the second part of the paper, the function $f(x)$ is used to study the properties of the function $g(x) = \int_0^x f(t) dt$. It is shown that $g(x)$ is a continuous function and that it satisfies the differential equation $g'(x) = f(x)$. The solution of this equation is $g(x) = \int_0^x e^{t^2/2} dt$. The value of $g(x)$ is determined by the initial condition $g(0) = 0$, which gives $g(x) = \int_0^x e^{t^2/2} dt$.

The third part of the paper is devoted to the study of the properties of the function $h(x) = \int_0^x g(t) dt$. It is shown that $h(x)$ is a continuous function and that it satisfies the differential equation $h'(x) = g(x)$. The solution of this equation is $h(x) = \int_0^x \int_0^t e^{s^2/2} ds dt$. The value of $h(x)$ is determined by the initial condition $h(0) = 0$, which gives $h(x) = \int_0^x \int_0^t e^{s^2/2} ds dt$.

The fourth part of the paper is devoted to the study of the properties of the function $k(x) = \int_0^x h(t) dt$. It is shown that $k(x)$ is a continuous function and that it satisfies the differential equation $k'(x) = h(x)$. The solution of this equation is $k(x) = \int_0^x \int_0^t \int_0^s e^{u^2/2} du ds dt$. The value of $k(x)$ is determined by the initial condition $k(0) = 0$, which gives $k(x) = \int_0^x \int_0^t \int_0^s e^{u^2/2} du ds dt$.

The fifth part of the paper is devoted to the study of the properties of the function $l(x) = \int_0^x k(t) dt$. It is shown that $l(x)$ is a continuous function and that it satisfies the differential equation $l'(x) = k(x)$. The solution of this equation is $l(x) = \int_0^x \int_0^t \int_0^s \int_0^u e^{v^2/2} dv ds dt$. The value of $l(x)$ is determined by the initial condition $l(0) = 0$, which gives $l(x) = \int_0^x \int_0^t \int_0^s \int_0^u e^{v^2/2} dv ds dt$.

The sixth part of the paper is devoted to the study of the properties of the function $m(x) = \int_0^x l(t) dt$. It is shown that $m(x)$ is a continuous function and that it satisfies the differential equation $m'(x) = l(x)$. The solution of this equation is $m(x) = \int_0^x \int_0^t \int_0^s \int_0^u \int_0^v e^{w^2/2} dw ds dt$. The value of $m(x)$ is determined by the initial condition $m(0) = 0$, which gives $m(x) = \int_0^x \int_0^t \int_0^s \int_0^u \int_0^v e^{w^2/2} dw ds dt$.

The seventh part of the paper is devoted to the study of the properties of the function $n(x) = \int_0^x m(t) dt$. It is shown that $n(x)$ is a continuous function and that it satisfies the differential equation $n'(x) = m(x)$. The solution of this equation is $n(x) = \int_0^x \int_0^t \int_0^s \int_0^u \int_0^v \int_0^w e^{z^2/2} dz ds dt$. The value of $n(x)$ is determined by the initial condition $n(0) = 0$, which gives $n(x) = \int_0^x \int_0^t \int_0^s \int_0^u \int_0^v \int_0^w e^{z^2/2} dz ds dt$.

The eighth part of the paper is devoted to the study of the properties of the function $o(x) = \int_0^x n(t) dt$. It is shown that $o(x)$ is a continuous function and that it satisfies the differential equation $o'(x) = n(x)$. The solution of this equation is $o(x) = \int_0^x \int_0^t \int_0^s \int_0^u \int_0^v \int_0^w \int_0^z e^{a^2/2} da ds dt$. The value of $o(x)$ is determined by the initial condition $o(0) = 0$, which gives $o(x) = \int_0^x \int_0^t \int_0^s \int_0^u \int_0^v \int_0^w \int_0^z e^{a^2/2} da ds dt$.

The ninth part of the paper is devoted to the study of the properties of the function $p(x) = \int_0^x o(t) dt$. It is shown that $p(x)$ is a continuous function and that it satisfies the differential equation $p'(x) = o(x)$. The solution of this equation is $p(x) = \int_0^x \int_0^t \int_0^s \int_0^u \int_0^v \int_0^w \int_0^z \int_0^a e^{b^2/2} db ds dt$. The value of $p(x)$ is determined by the initial condition $p(0) = 0$, which gives $p(x) = \int_0^x \int_0^t \int_0^s \int_0^u \int_0^v \int_0^w \int_0^z \int_0^a e^{b^2/2} db ds dt$.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22416

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Samuel Keith Harrison

2. Date of Death

Month

Day

Year

July

03

1997

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

217-36-4422

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

5/24/29

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

PA

10b. County

York

10c. City, Town or Location

Delta

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

453 Wise Road

10f. Zip Code

17314

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dairy Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Crawford Lemon Harrison

18. Mother's Name (First, Middle, Maiden Surname)

Rhoda Sparks

19a. Informant's Name/Relationship (Type, Print)

Ethelda M. Harrison- wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

453 Wise Road, Delta, PA 17314

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bowers Cemetery

Date

7/7/97

20c. Location - City or Town, State

New Freedom, PA

21. Signature of Funeral Service Licensee

John P. Tillet

22. Name and Address of Facility

Harkins F.H. Inc., 600 Main St., Delta, PA 17314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or Injury that initiated events resulting in death) Last

f. Respiratory Depression

Due to (or as a consequence of):

g. Intracerebral Hemorrhage

Due to (or as a consequence of):

h. Hypertension

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Roughly [Signature]

29c. License number

D23446

29d. Date signed (Month, Day, Year)

7/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith 104 1716 Harford Rd Fallston Maryland 21047

31. Date filed (Month, Day, Year)

JUL 7 1997

32. Signature of Registrar

[Signature]

State
RegistrarSamuel Keith Harrison
Baltimore, Maryland 21215-0020

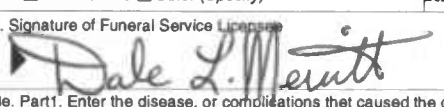
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

97-22417

| | | | | | | | | |
|---|---|--|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
COLLEEN BETH HENRY | | | | 2. Date of Death
Month JULY Day 9 Year 1997 | | 3. Time of Death
9:04AM | |
| | 4a. Facility Name (If not institution, give street and number)
CUMBERLAND MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
528-90-7017 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
42 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JULY 8 1955 | 9. Birthplace (State or Foreign Country)
CALIF. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
FLA. | 10b. County
ORANGE | 10c. City, Town or Location
ORLANDO | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
9454 FIRST AVE. | | | | 10f. Zip Code
32824 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PUBLIC SUPER MARKETS | | | 16b. Kind of Business/Industry
DELI MANAGER | | |
| | 17. Father's Name (First, Middle, Last)
RICHARD JAMESON SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EVELYN BETH BATES | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
SCOTT ELMER HENRY HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9454 FIRST AVE. ORLANDO, FLA. 32824 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
REST LAWN CEMETERY | | Date
JULY 14 1997 | | 20c. Location - City or Town, State
LA VALE, MARYLAND | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME
404 DEGATUR STREET CUMBERLAND MARYLAND | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE PNEUMONIA ASSOCIATED WITH MIXED DRUG INTOXICATION
Due to (or as a consequence of):

b. Due to (or as a consequence of):

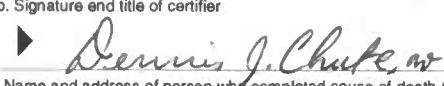
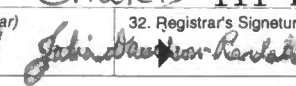
c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE PNEUMONIA ASSOCIATED WITH MIXED DRUG INTOXICATION
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HISTORY OF REACTIVE AIRWAY DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
found 7/9/97 | | 28b. Time of Injury
found 7:30M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred
unknown | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
found in house | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
11521 Bishop Lane
Cumberland, Maryland | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
JULY 10, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 14 1997 | | 32. Registrar's Signature
 | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22418**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Evert Hayes

2. Date of Death

Month

Day

Year

7 14 1997

3. Time of Death

11:05 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Residence: 255 Jackson Park Road

4b. City, Town, or Location of Death

Port Deposit

4c. County of Death

Cecil

5. Social Security Number

215-54-0403

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 16, 1932

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Port Deposit

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

255 Jackson Park Road

10f. Zip Code

21904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: 1950-195413. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Seven Years

College (1-4 or 5+)

18e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Aircraft Mechanic

16b. Kind of Business/Industry

U.S. Government
Maryland National Guard

17. Father's Name (First, Middle, Last)

Charles Daniel Hayes

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Faye Pickle

19a. Informant's Name/Relationship (Type, Print)

Joan Ann Jester-Hayes (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

255 Jackson Park Road, Port Deposit, Maryland 21904

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hopewell Cemetery

Date

7/17/97

20c. Location - City or Town, State

Port Deposit, Maryland

21. Signature of Funeral Service Licensee

Thomas M. Patterson Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home
Perryville, Maryland 21903-018823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- COPD

- DEB. DISC DS.

- CHF

- PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Thomas M. Patterson Sr.

29c. License number

D42800

29d. Date signed (Month, Day, Year)

7/14/97

30. Name and address of person who completed cause of death (Item 23a). (Type, Print)

E. Bronzo 3145 Union Ave, Apt 6, KMD, 21078

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

*Julia Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8 IVA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

91 22419

| | | | | | | | | |
|---|--|---------------------------------|---|--|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Doris Beatrice Harris | | | | 2. Date of Death
Month July Day 5 Year 97 | | 3. Time of Death
2:27 PM | |
| | 4a. Facility Name (If not institution, give street and number)
St. Agnes Healthcare | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
368-28-4510 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb. 17 1929 | 9. Birthplace (State or Foreign Country)
Michigan |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Frederick | | 10c. City, Town or Location
Frederick | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
2404 Ellsworth Way | | | 10f. Zip Code
21701 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Pharmacy Technician | | 16b. Kind of Business/Industry
Pharmacy | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Joseph Martell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jeanette Blong | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Michelle Lindsay daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
905 Edmondson Ave. Catonsville MD 21228 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springfield Cemetery | | 20c. Location - City or Town, State
7/9/97 Sykesville MD | | 22. Name and Address of Facility
Haight Funeral Home
P.O. Box 195 Sykesville MD 21784 | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
c. Sepsis
Due to (or as a consequence of):
d. Small Cell Lung Cancer | | | | | | | Approximate Interval Between Onset and Death
14 days |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
Eaton Lambert Syndrome | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury et Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | 29b. Signature and title of certifier
<i>[Signature]</i> |
| | 29c. License number
047484 | | 29d. Date signed (Month, Day, Year)
July 5, 1997 | | | | | |
| State
Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ERIC SHEPARD MD ST. Agnes Healthcare 900 Catonsville Ave, Baltimore | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 09 1997 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22420

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Earle Haines

2. Date of Death

Month 7 Day 4 Year 97

3. Time of Death

3:45 PM

4a. Facility Name (If not institution, give street and number)

252 Bucher John Rd.

4b. City, Town, or Location of Death

Union Bridge

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

216-10-8020

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 27, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Union Bridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

252 Bucher John Rd.

10f. Zip Code

21791

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing Factory

17. Father's Name (First, Middle, Last)

Edgar Angell

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Warner

19a. Informant's Name/Relationship (Type, Print)

Roland Haines/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

252 Bucher John Rd. Union Bridge, MD 21791

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. View Cemetery

Date

7/7/97

20c. Location - City or Town, State

Union Bridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hartzler Funeral Home

Union Bridge, MD 21791

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Non Small Cell Lung Carcinoma

Due to (or as a consequence of):

1 yr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma Larynx

Carcinoma Stomach

Emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D 906

29d. Date signed (Month, Day, Year)

7/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. H. CARICAFE MD P.O. Box 1110 Union Bridge Md. 21791

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22421

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys S. Harlow

2. Date of Death

Month
JulyDay
3,Year
1997

3. Time of Death

1:00 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8800 Neadhouse

4b. City, Town, or Location of Death

North Beach

4c. County of Death

Anne Arundel

5. Social Security Number

217-32-0095

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 31, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mount Rainier

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3001 Queens Chapel Road

10f. Zip Code

20712

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Alexander Sellers

18. Mother's Name (First, Middle, Maiden Surname)

Florence May von Werder

19a. Informant's Name/Relationship (Type, Print)

Barbara Gray - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 1247, North Beach, Maryland 20714

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

07/07/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Henry S. L...

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Metastatic Breast Ca

Due to (or as a consequence of):

b. Brain Metastasis

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

8 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. R. ...

29c. License number

D37588

29d. Date signed (Month, Day, Year)

July 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nasr, M.D. 135 W. Dares Beach Road, Prince Frederick, MD 20678

State
Registrar

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

John ...

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22422

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|--|--|---|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)
DOROTHY MAE HART | | 2. Date of Death
Month JULY Day 9 Year 1997 | | 3. Time of Death
12:40AM | |
| 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES GENERAL HOSPITAL CENTER | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES | |
| 5. Social Security Number
577-50-1427 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
59 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
DEC. 23, 1937 |
| 9. Birthplace (State or Foreign Country)
SOUTH CAROLINA | | | | | |
| Usual Residence of Decedent | | | | | |
| 10e. State
MARYLAND | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
SEAT PLEASANT | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
7018 HASTINGS DRIVE | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
UNITED STATES | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NATIONAL DEFENSE UN. | | 16b. Kind of Business/Industry
GOVERNMENT | |
| 17. Father's Name (First, Middle, Last)
THEODORE HALL | | 18. Mother's Name (First, Middle, Maiden Surname)
BERTHA ABNEY HALL | | | |
| 19a. Informant's Name/Relationship (Type, Print)
WILLIAM F. HART, JR. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7018 HASTINGS DRIVE, SEAT PLEASANT, MD 20743 | | | |
| 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HARMONY MEM. PARK CEM. | | 20c. Location - City or Town, State
LANDOVER, MARYLAND | |
| 21. Signature of Funeral Service Licensee
Edward M. Dudley | | 22. Name and Address of Facility
DUDLEY FUNERAL HOME
3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death)
a. Brain death
Due to (or as a consequence of):
b. Cerebral vascular accident
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease
metastatic ovarian cancer | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
L. Bahadori | | 29c. License number
D 47928 | |
| 29d. Date signed (Month, Day, Year)
7/9/97 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
L. Bahadori Prince Georges Hospital Cheverly, MD | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 10 1997 | | 32. Registrar's Signature
John Anderson-Randall | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22423

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JASON DOUGLASS HOPKINS | | | | 2. Date of Death
Month Day Year
JULY 03 1997 | | 3. Time of Death
9:57 PM | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
578-15-7939 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
19 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 9, 1977 | |
| | 9. Birthplace (State or Foreign Country)
Washington, D. C. | | 10a. State
District of Columbia | | 10b. County
Washington | | 10c. City, Town or Location
Washington | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2612 Naylor Road, S. E., Apt. T-2 | | 10f. Zip Code
20020 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Unemployed | | 16b. Kind of Business/Industry
N/A | | 17. Father's Name (First, Middle, Last)
Barry Hopkins | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Denise Hancock | | 19a. Informant's Name/Relationship (Type, Print)
Denise Walton - Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2612 Naylor Road, S.E., #T-2, Washington, D.C. 20020 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. Date
7/9/97 | | 20d. Location - City or Town, State
Landover, MD | | 21. Signature of Funeral Service Licensee
John T. Stewart III | |
| | 22. Name and Address of Facility
STEWART FUNERAL HOME, INC.
4001 Benning Road, N. E., Washington, D. C. | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Multiple Gunshot Wounds
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
7/3/97 | | 28b. Time of Injury
unknown M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| State Registrar | 28d. Describe how injury occurred
Subject shot | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
2901 E. Nelson Place Washington District of Columbia | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Theodore M. King | |
| | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
JULY 04 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | 31. Data filed (Month, Day, Year)
JUL 09 1997 | |
| 32. Registrar's Signature
John Anderson-Randall | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22424

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICIA OLIVIA HOUCK

2. Date of Death

July 4

Day

97

Year

3. Time of Death

3 AM

4a. Facility Name (If not institution, give street and number)

2160 Herring Way

4b. City, Town, or Location of Death

St. Leonard

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

579-34-7057

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

January 25, 1907

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

St. Leonard

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2160 Herring Way

10f. Zip Code

20685

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Caucasian15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Prince Georges & D.C.
School System

17. Father's Name (First, Middle, Last)

Lorenzo S. Hill

18. Mother's Name (First, Middle, Maiden Surname)

Anna Melissa Nichols

19a. Informant's Name/Relationship (Type, Print)

Frank K. Halley, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1011 Kings Valley Drive, Mitchellville, MD 20721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mount Olivet Cemetery

Date

July 8,
1997

20c. Location - City or Town, State

Frederick, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home
9013 Annapolis Road, Lanham, MD 2070623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

SEVERE ALZHEIMER'S DEMENTIA - 2 yrs

Approximate
Interval Between
Onset and DeathSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lasta. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease & old

Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

A. T. Munshi M.D. Attending Physician

29c. License number

D 19427

29d. Date signed (Month, Day, Year)

7/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. T. MUNSHI, Suite 303, 110 HOSP RD, PRINCE FREDERICK MD 20678

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

John A. Russell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22425

Amended # 10b-10c. P.G.C. 7/8/97 CR

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

DOROTHY L. HAWKINS

2. Date of Death

Month Day Year
JUNE 29 1997

3. Time of Death

13:31 PM

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

579-26-4633

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
4/8/23

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State
D.C.

10b. County

Washington

10c. City, Town or Location

612 Franklin St., N.E. Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

612 Franklin St., N.E.

10f. Zip Code

20017

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Law Office

17. Father's Name (First, Middle, Last)

Linwood Gregory

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Frazier

19a. Informant's Name/Relationship (Type, Print)

Beverly Queen/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9510 Clocktower Ln., Columbia, Md. 21046

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Mem. Park 7/7/97

Date

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Xany H. Pratt

22. Name and Address of Facility

H.S. Washington & Sons, inc.
4925 Burroughs Ave., N.E.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Lt foot gangrene sepsis
Due to (or as a consequence of):b. old Coronary Artery Accident
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

48 hr.

710 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAXMI BERWA 7706 OLD BRANCH Ave. Clinton MD 20735

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

John Anderson-Randall

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

①

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

57 22426

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Patrick Jordan Sr.

2. Date of Death

Month Day Year
July 2 1997

3. Time of Death

3:25 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8101 Connecticut Avenue Apt. S-608

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

5. Social Security Number

215-26-3193

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 25, 1914

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8101 Connecticut Avenue Apt. S-608

10f. Zip Code

20815

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

General Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Patrick F. Jordan

18. Mother's Name (First, Middle, Maiden Surname)

Mary F. Gallagher

19a. Informant's Name/Relationship (Type, Print)

Joseph Patrick Jordan Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4749 Oak Road, Shady Side, MD 20764

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mount Olivet Cemetery

Date

7/7/97

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

William J. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE MYELOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kevin G. Nealon MD

29c. License number

D23127

29d. Date signed (Month, Day, Year)

July 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin G. Nealon, MD 5530 Wisconsin Avenue, Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

JUL 7 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

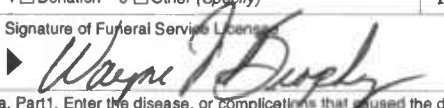
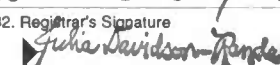
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Form #10a, 10b, 10c, 10e, 10f, 7/10/97, BMW, Montg

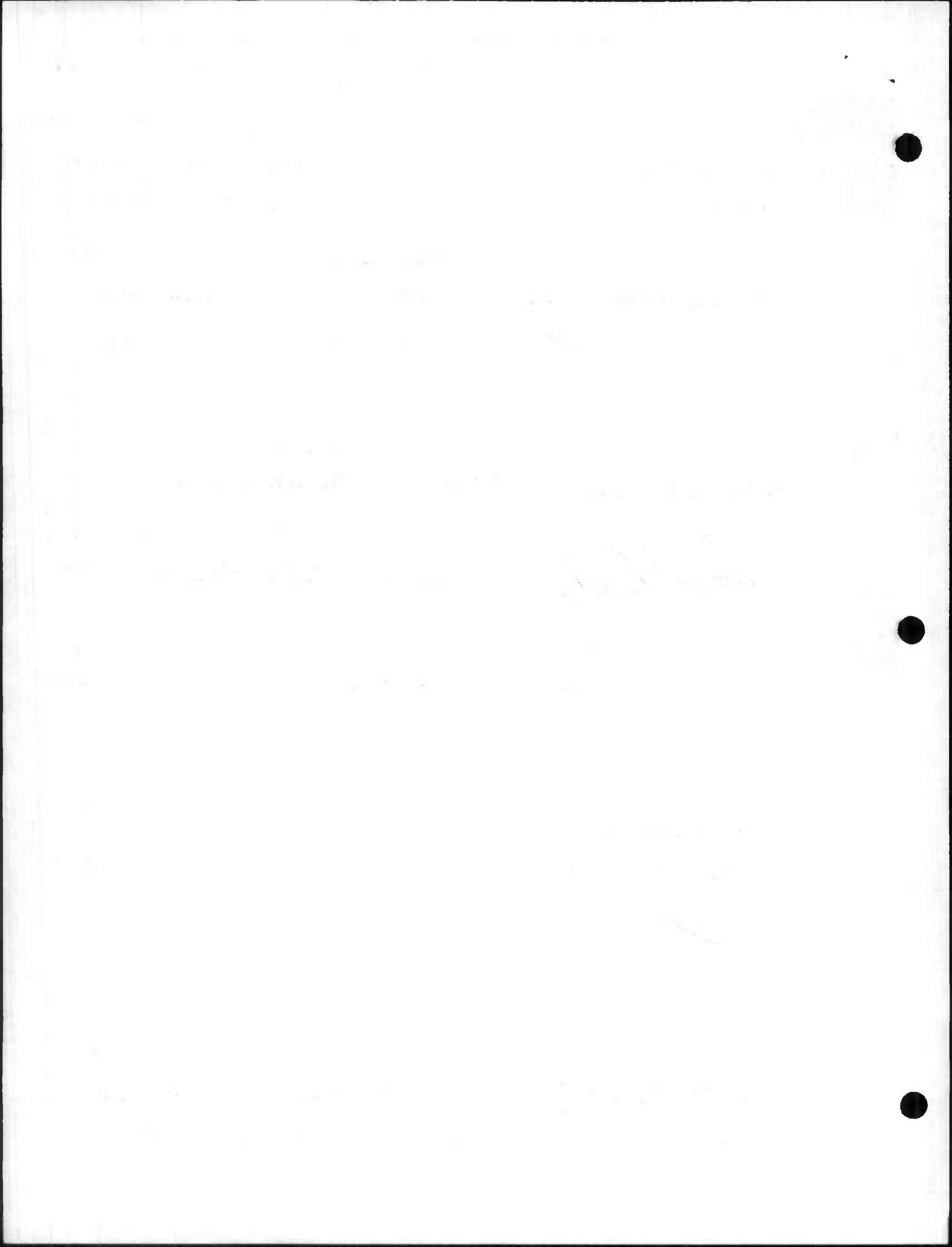
Reg. No.

97 22427

| | | | | | | | | |
|---|---|---|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Virginia M. Jones | | | | 2. Date of Death
Month July Day 3 Year 1997 | | 3. Time of Death
5:10 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Home | | | | 4b. City, Town, or Location of Death
Hyattsville | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
264-80-6830 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 24, 08 | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10. Usual Residence of Decedent
10e. State N/A 10f. County Prince Georges 10g. City, Town or Location Hyattsville 10h. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Street and Number 5805 Queens Chapel Rd., #342 | | 12. Zip Code 20017 | |
| To Be Completed by Funeral Director | 13. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 14. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 15. Was Decedent of Hispanic Origin? (Specify Yes or No)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 16. Race - American Indian, Black, White, etc.
Specify: White | |
| | 17. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 19. Kind of Business/Industry
Domestic | | | |
| | 20. Father's Name (First, Middle, Last)
Harry Mueller | | | | 21. Mother's Name (First, Middle, Maiden Surname)
Katherine O'Brien | | | |
| | 22. Informant's Name/Relationship (Type, Print)
J. Phillip Jones / Son | | | | 23. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
901 Quincy St., #3, Wash., N.E. 20017 | | | |
| | 24. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 25. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Park | | 26. Date
7-8-1997 | | 27. Location - City or Town, State
Cumberland, Md. | |
| | 28. Signature of Funeral Service Licensee
 | | | | 29. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc., 11800 New Hampshire Ave., Silver Spring, Md. 20904 | | | |
| | 30. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Anorexia
Due to (or as a consequence of):
b. COLON CARCINOMA METASTATIC TO LUNG
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death
1 month
MONTHS | | | |
| | 31. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SENILE DEMENTIA
POLYMYALGIA RHEUMATICA | | | | 32. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 33. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 34. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 35. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 36. Date of Injury (Month, Day, Year)
7/10/97 | | 37. Time of Injury
M | | 38. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 39. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 40. Describe how Injury occurred | | 41. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 42. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 43. Signature and Title of certifier
 | | 44. License number
022780 | | |
| 45. Date signed (Month, Day, Year)
7/11/97 | | 46. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Peter M Schisler 7500 Greenway Ctr. Dr. Greenbelt Md 20770 | | 47. Date filed (Month, Day, Year)
JUL 08 1997 | | 48. Registrar's Signature
 | | |
| 49. State Registrar | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97-22428

| | | | | | | | | | | | | |
|---|---|--|---|--|---|---|--|---|--|--|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLES H. JACKSON | | | | | 2. Date of Death
Month July Day 6 Year 1997 | | 3. Time of Death
10:57 AM | | | | |
| | 4e. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | | | | |
| Funeral
Director | 5. Social Security Number
577-46-5983 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
65 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 4, 1932 | | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
D.C. | | | 10b. County
N/A | | 10c. City, Town or Location
Washington | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
1461 Leegate Road, N.W. | | | | | 10f. Zip Code
20012 | | 10g. Citizen of What Country?
United States | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: 1952 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+ | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant Superintendent | | | 16b. Kind of Business/Industry
Alexandria Public Schools | | | | |
| 17. Father's Name (First, Middle, Last)
Clifton Jackson | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Naomi Churchwill | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Barbara T. Jackson (wife) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1461 Leegate Road, N.W., Washington, D.C. 20012 | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Cemetery | | 20c. Location - City or Town, State
Suitland, Maryland | | 20d. Date
7/12/97 | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
McGuire Funeral Service, Inc.
7400 Georgia Ave. N.W., Washington, D.C. 20012 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | | |
| Immediate Cause (Final disease or condition resulting in death)
e. PULMONARY EMBOLUS | | | | | | | | | | ONE HOUR | | |
| Due to (or as a consequence of): | | | | | | | | | | | | |
| b. DEEP VENOUS THROMBOSIS | | | | | | | | | | 5 DAYS | | |
| Due to (or as a consequence of): | | | | | | | | | | | | |
| c. ADENOCARCINOMA OF THE PROSTATE | | | | | | | | | | 2 MONTHS | | |
| Due to (or as a consequence of): | | | | | | | | | | | | |
| d. | | | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | 29b. Signature and title of certifier
 M.D. | | 29c. License number
B 33617 | | 29d. Date signed (Month, Day, Year)
JULY 8, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARK H. RATNER M.D. 15225 SHADY GROVE ROAD ROCKVILLE, MARYLAND 20850 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 11 1997 | | | | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22429

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOIS A. JACKSON

2. Date of Death

Month Day Year
JUNE 26, 1997

3. Time of Death

8:58am

4a. Facility Name (If not institution, give street and number)

Prince George Community Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George

Funeral
Director

5. Social Security Number

579-56-2047

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sep. 8, 1943

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince george

10c. City, Town or Location

Capital Heights

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6920 Walker Mill Road #B2

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Hostess

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

James G. Fuller

18. Mother's Name (First, Middle, Maiden Surname)

Clara J. Williams

19a. Informant's Name/Relationship (Type, Print)

James Woods/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2734 Loring Drive, #102, Forestville, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Memorial Park

Date

7/3/97

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.
600 Kennedy Street, N. W., DC 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. CARDIAC ARREST

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

MINUTES

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Pulmonary Hypertension

Due to (or as a consequence of):

YEARS

c. TRICUSPID INSUFFICIENCY

Due to (or as a consequence of):

YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D31069

29d. Date signed (Month, Day, Year)

JUNE 28, 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George H. Bone, M.D. 9602-F Martin Luther King Highway, Lanham, MD 20706

31. Date filed (Month, Day, Year)

JUL 8 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22430

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Philip Jamieson

2. Date of Death

Month Day Year
June / 29 / 1997

3. Time of Death

6:54 AM

4a. Facility Name (If not institution, give street and number)

425 Cokesbury Road

4b. City, Town, or Location of Death

Port Deposit

4c. County of Death

Cecil

5. Social Security Number

578-18-2220

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 22, 1921

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Port Deposit

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

425 Cokesbury Road

10f. Zip Code

21904

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

-

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

None

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Archibald Mitchell Jamieson

18. Mother's Name (First, Middle, Maiden Surname)

Olive Simpson

19a. Informant's Name/Relationship (Type, Print)

Steven H. Schiff/ Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15729 Crabbs Branch Way, Rockville, MD 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Cemetery

Date

July 7, 1997

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

M00689

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue,
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

10 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. Randall MD

29c. License number

D 52087

29d. Date signed (Month, Day, Year)

June 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Union Hospital, 106 Bow Street, Elkton, MD 21921

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 + 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22431

| | | | | | | | | |
|--|--|--|---|--|--|--------------------------------|---|---|
| Physician
/Medical
Examiner | 1. Decedant's Name (First, Middle, Last)
Lilly John | | | | 2. Date of Death
Month June Day 14 , Year 1997 | | 3. Time of Death
4:17 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death
Clinton | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
N/A | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
75 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
July 25, 1921 | 9. Birthplace (State or Foreign Country)
Pennsylvania |
| | Usual Residence of Decedant | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | | 10b. County
P.G. | | 10c. City, Town or Location
Capitol Heights | | 10d. Inside City Limits
1 Yes 2 No | |
| | 10e. Street and Number
5825 Martin Luther King Jr. Hwy. | | | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) ----- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | | |
| | 17. Father's Name (First, Middle, Last)
Adoff John | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary John | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Louis Mitchell (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743
5825 Martin Luther King Jr. Hwy. Capitol Heights, Md. | | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery | | Data
6/18/97 | | 20c. Location - City or Town, State
Washington D.C. | |
| | 21. Signature of Funeral Service Licensee
<i>Thomas S. Chamberlain</i> #670 | | | | 22. Name and Address of Facility
Chambers Funeral Homes, P.A.
5801 Cleveland Ave. Riverdale, Md. 20737 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Cause (Final disease or condition resulting in death)

a. Ventricular Tachycardia.
Due to (or as a consequence of):

b. Acute myocardial infarction.
Due to (or as a consequence of):

c. Atherosclerotic Heart Disease.
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death
15 minutes
4 days
more than 1 year. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Renal Failure.
Both Lower Extremity Ischaemia. | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 Yes 2 No | | | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | |
| | 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | |
| | 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>Gregory A. Anderson</i> | | | |
| State Registrar | 29c. License number
D0050653 | | | | 29d. Date signed (Month, Day, Year)
6-14-97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GYAN SURANA M.D.
7501 Surratts Road. Suite 302. Clinton. Md. | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 20 1997 | | | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22432

| | | | | | | | | | |
|--|---|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Esther J. R. Johnson | | | | 2. Date of Death
Month July Day 5 Year 1997 | | 3. Time of Death
9:06 A | | |
| | 4a. Facility Name (If not institution, give street and number)
307 Frederick Avenue | | | | 4b. City, Town, or Location of Death
Rockville | | 4c. County of Death
MONTGOMERY | | |
| Funeral
Director | 5. Social Security Number
216-30-4848 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 12, 1908 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | | |
| | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
307 Frederick Avenue | | | | 10f. Zip Code
20850 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th | | Collage (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Custodian | | 16b. Kind of Business/Industry
Montg. Co. Schools | | |
| | 17. Father's Name (First, Middle, Last)
John H. Weedon | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Clara Nichols | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Walter Johnson (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
301 Frederick Ave., Rockville, MD 20850 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Park Cem | | Date
7/9/97 | | 20c. Location - City or Town, State
Rockville, MD | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Diabetes Mellitus, Type 1 - Complications of
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Heart Disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D21977 | | 29d. Date signed (Month, Day, Year)
7/7/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT L. ROBINSON, MD 2730 UNIVERSITY BLVD W #30, WASHINGTON, MD 20902 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 8 1997 | | 32. Registrar's Signature
 | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22433

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ruby Johnson | | | | 2. Date of Death
Month July Day 4 Year 1997 | | 3. Time of Death
1510 | |
| | 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
233-72-6098 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
95 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug., 11, 1901 | 9. Birthplace (State or Foreign Country)
W. Virginia |
| | Usual Residence of Decedent | | | | 10e. State
Florida | | 10b. County
Volusia | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10f. Zip Code
32728 | | 10g. Citizen of What Country?
United States | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Domestic | | | | |
| 17. Father's Name (First, Middle, Last)
Elbert Ferrell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lena Haner | | | | |
| 19a. Informant's Name/Relationship (Type, Print) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1612 Falmouth Ave., Deltona, Fl. 32728 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ridgelawn Burial Park | | 20c. Location - City or Town, State
7-8-97 Barboursville, W. Va. | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Md. 20904 | | | | |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Pulmonary Edema
Due to (or as a consequence of):
Acute Myocardial Infarction
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
2 weeks
2 weeks | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
29300 | | 29d. Date signed (Month, Day, Year)
July 04, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Robert L. Gold 15225 Shady Grove Road Rockville, Md 20850 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 08 1997 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22434

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARION S. JOHNSON

2. Date of Death

June 11 1997

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

45 Liberty St.

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

213-52-9811

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 29, 1944

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

* Yes 2 ☐ No

10e. Street and Number

485 Washington St

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Elmer Christy

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Randolph

19a. Informant's Name/Relationship (Type, Print)

Matthew Johnson - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

485 Washington St

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Mem Garden 6-14

Date

20c. Location, City or Town, State

Aberdeen, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

BENARD Funeral Home
552 Lewis St, Harford, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D33099

29d. Date signed (Month, Day, Year)

7/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Promila Surf MD

138 Cathedral Street

31. Date filed (Month, Day, Year)

JUL 11 1997

32. Registrar's Signature

[Signature]

ELICTON, MD 21921

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22435

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leola Frances Jones

2. Date of Death

07 July 10

Year

97

3. Time of Death

00:40

4e. Facility Name (If not institution, give street and number)

708-A Bradley Road

4b. City, Town, or Location of Death

Ocean City

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

578-52-0485

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 16, 1916

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

708-A Bradley Road

10f. Zip Code

21842

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Ira J. Green

18. Mother's Name (First, Middle, Maiden Surname)

Teenie E. Cook

19a. Informant's Name/Relationship (Type, Print)

James Greene (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11416 Brandywine Road Clinton, Maryland 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

July 14

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Burbage Funeral Home 108 William St. Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 minute

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCVD

Due to (or as a consequence of):

Many yrs

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

206241

29d. Date signed (Month, Day, Year)

07-10-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOROTHY C. HOLZWORTH, M.D. 205 SNOW ST. SNOW HILL, MD. 21863

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

57 22436

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gary K. Jamison

2. Date of Death

Month Day Year
July 7, 1997

3. Time of Death

6:20 p.m.

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

495-38-5768

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 19, 1934

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bladensburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4307 56th Avenue

10f. Zip Code

20710

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Geologist

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Byron Ralph Jamison

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Elaine Tenneson

19a. Informant's Name/Relationship (Type, Print)

Linda L. Jamison

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4307 56th Avenue, Bladensburg, Maryland 20710

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD Veteran's Cemetery

Date

07/11/97

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

PULMONARY EMPHYSEMA

e.

Due to (or as a consequence of):

BRONCHIAL ASTHMA

b.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

5 YRS

10 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES, CANCER OF THE PROSTATE

OSTEOPOROSIS DUE TO PRENATAL

INTERPLAY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Signature and title of certifier
29c. License number
29d. Date signed (Month, Day, Year)

29c. License number

MD 2012

July 9, 1997

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

Dr. Goldberg 9801 Georgia Avenue, Wheaton, Maryland

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text, possibly a signature or date, located in the middle-left section of the page.

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22437

| | | | | | | | | | |
|--|---|--|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert Leon Jeffries | | | | 2. Date of Death
Month July Day 02 Year 1997 | | 3. Time of Death
11:00PM | | |
| | 4e. Facility Name (If not institution, give street and number)
Mariner Nursing Home | | | | 4b. City, Town, or Location of Death
Bethesda Maryland | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
223-18-2580 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 26 1913 | | |
| | 9. Birthplace (State or Foreign Country)
West Virginia | | 10a. State
Md | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
5721 Gosvenor Lane | | 10f. Zip Code
20814 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> College 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Accountant | | 16b. Kind of Business/Industry
Education | | | | | |
| 17. Father's Name (First, Middle, Last)
Eugene Jefferies | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosa Lee Carrington | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ms. Nancy Lockett daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1221 Van Buran Street, N. W. Wash. D. C. | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial | | Date
7/7/97 | | 20c. Location - City or Town, State
Landover, MD | | 20d. Location - City or Town, State
Prince Georges Md. | |
| 21. Signature of Funeral Service Licensee
<i>Shirley Latney</i> | | | | 22. Name and Address of Facility
Latney's Funeral Home
3831 Georgia Ave. N. W. Wash. D. C. | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
Cerebrovascular accident

Due to (or as a consequence of):
Hypertension

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death

minutes

years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation
seizure disorder
dementia
hypoproteinemia | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
David A. Blass MD | | 29c. License number
D23911 | | 29d. Date signed (Month, Day, Year)
July 5, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
David A. Blass MD 9410 Old Georgetown Rd. Bethesda, Md. 20814 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 09 1997 | | | | 32. Registrar's Signature
<i>Judi Anderson-Randall</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

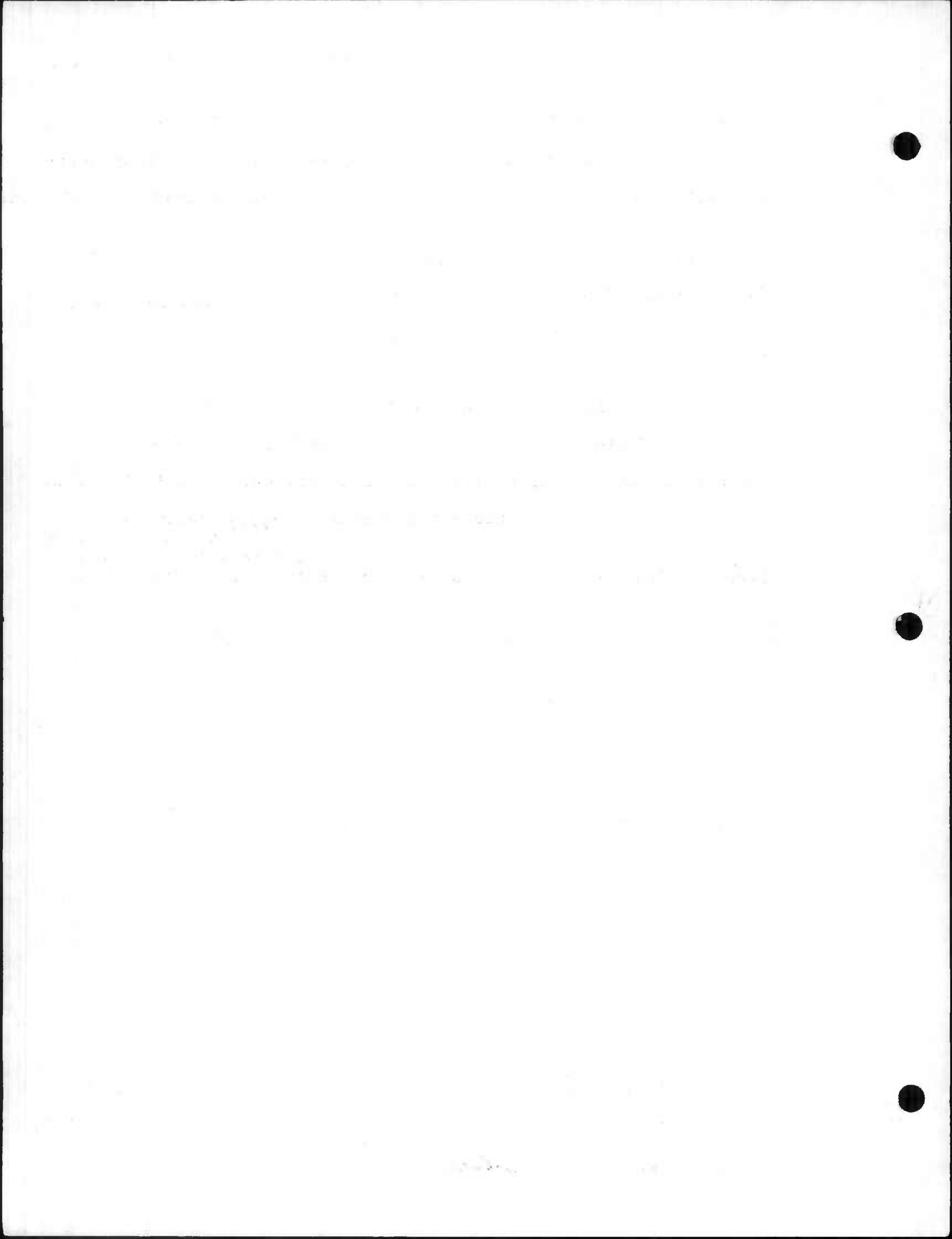
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22438

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER B. JOHNSON

2. Date of Death

JULY 4, 1997 Year

3. Time of Death

10:40 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6511 100th Ave.

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

212 54 5347

6. Sex

M 2 F

7. Age (in yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 30, 1949

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Lanham

10d. Inside City Limits

XX Yes 2 No

10e. Street and Number

6511 100th Ave.

10f. Zip Code

20706

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☐ No
 If Yes, Give Year or Dates: 69-72

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

New Site Router

16b. Kind of Business/Industry

WSSC

17. Father's Name (First, Middle, Last)

JOSEPH JAMES JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

RUTH AGNES DIGGLE

19a. Informant's Name/Relationship (Type, Print)

ANNA E. JOHNSON /SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1224 HOLLY AVE., SHADYSIDE, MD. 20764

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

July 10, 1997

20c. Location - City or Town, State

Cheltenham, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Robert E. Evans Funeral Home Inc 16000 Annapolis
 RD., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Adiposarcoma Recur, metastatic

Approximate Interval Between Onset and Death

months

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D32261

29d. Date signed (Month, Day, Year)

7-7-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD J. FELDMAN MD 9700 ANNAPOLIS RD, LANHAM MD 20706

31. Date filed (Month, Day, Year)

JUL 11 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

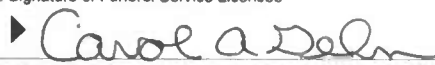
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22439

Reg. No.

**Physician
/Medical
Examiner**

**Funeral
Director**

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Enos Smith Knecht | | | | 2. Date of Death
Month July Day 5 Year 1997 | | 3. Time of Death
5:25 AM | |
| 4a. Facility Name (If not institution, give street and number)
3253 Jones Road | | | | 4b. City, Town, or Location of Death
Woodbine | | 4c. County of Death
Howard | |
| 5. Social Security Number
229-52-1411 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday)
98 Yrs. | | 8. Date of Birth (Month, Day, Year)
December 17, 1898 | |
| 9. Birthplace (State or Foreign Country)
Michigan | | Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | | 10b. County
Howard | | 10c. City, Town or Location
Woodbine | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
3253 Jones Road | | | | 10f. Zip Code
21797 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
business manager | | 16b. Kind of Business/Industry
bookstore | |
| 17. Father's Name (First, Middle, Last)
Andrew Jackson Knecht | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Emily Smith | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Marilyn Elise Knecht-Froelich | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3253 Jones Road, Woodbine, Maryland 21797 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | 20c. Date
7-6-97 | | 20d. Location - City or Town, State
Beltsville, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910 | | | |



To Be Completed by Funeral Director

**Physician
/Medical
Examiner**

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Alzheimers Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
03516Z | | 29d. Date signed (Month, Day, Year)
July 5, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael S. Schindler, M.D., 10801 Lockwood Drive, Silver Spring, Maryland 20901 | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 07 1997 | | 32. Registrar's Signature
 | | | |

**State
Registrar**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22440

| | | | | | | | | |
|---|--|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Douglas Tarone Koonce, II | | | | 2. Date of Death
Month Day Year
JULY 6, 1997 | | 3. Time of Death
4:28 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death
Frederick | | 4c. County of Death
FREDERICK | |
| Funeral
Director | 5. Social Security Number
219-47-6057 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 9 | | 8. Date of Birth (Month, Day, Year)
Sept. 9, 1996 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Frederick | | 10c. City, Town or Location
Frederick | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
32C Sagner Drive | | 10f. Zip Code
21701 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A
College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | | 16b. Kind of Business/Industry
None | | | | |
| 17. Father's Name (First, Middle, Last)
Reginald Rhodes | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Tara Price | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Tara Price (Mother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
32C Sagner Dr., Frederick, MD 21701 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Park Cem | | Date
7/10/97 | | 20c. Location - City or Town, State
Rockville, MD | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 | | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asystole
Due to (or as a consequence of):

b. Septo-optic dysplasia
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death
40 min. | | | | | | | | |
| 23a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

Panhypopituitarism | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
D33531 | | 29d. Date signed (Month, Day, Year)
7-6-97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James P Lee, mo 1475 Taney Ave., Frederick, MD 21702 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 11 1997 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerState
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amend #10a, 10b, 10c, 10e, 10f, 18, 7/9/97, BW, Montg. Co.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ali Abdul-Rahman Khalil

2. Date of Death

Month

Day

Year

JULY

3

1997

3. Time of Death

1425

4a. Facility Name (If not institution, give street and number)

ST. AGNES HEALTHCARE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

n/a

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 30, 1928

9. Birthplace (State or Foreign Country)

Jerusalem

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

New York Al-Khobar, Saudi Arabia

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

Prince Hraud Street

415 E. 37th St., 33N

10f. Zip Code

10016 31952

10g. Citizen of What Country?

Saudi Arabia

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ARAMCO official (Saudi Oil Co.) oil company

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Abdul-Rahman Ali Khalil

18. Mother's Name (First, Middle, Maiden Surname)

Fatemeh Mohammed Adawiyah

19a. Informant's Name/Relationship (Type, Print)

Mona Ali Khalil/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

415 E. 37th St., #33N, New York, N.Y. 10016

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

National Memorial Park July 5, 97 Falls Church, Va.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

2222 Wisconsin Ave., N.W., Wash., DC 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

b. ACUTE ANTEROSEPTAL MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

2 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NON-INSULIN DEPENDANT DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

29c. License number

P10873

29d. Date signed (Month, Day, Year)

JULY 3, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MAZEN GHANI, M.D. ST. AGNES HEALTHCARE, 900 CATON AVE, BALTIMORE 21229

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

John Davidson-Rendall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Irene Keizur

2. Date of Death

Month Day Year
July 5, 1997

3. Time of Death

4:23 AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

220-48-1710

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 5, 1909

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3700 International Drive

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Molnar

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Gonczi

19a. Informant's Name/Relationship (Type, Print)

Norman L. Stant

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 Tivoli Lake Court, Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

7-6-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Del...

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

SEPTIC

Approximate Interval Between Onset and Death

DAYS

f.

Due to (or as a consequence of):

OBSTRUCTIVE JAUNDICE

DAYS

g.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

h.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHOLERA DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D38457

29d. Date signed (Month, Day, Year)

JULY 5, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type Print)

NAKUL GOYAL MD, 1011 PRINCE PHILIP DR, OLNEY MD 20832

31. Date filed (Month, Day, Year)

JUL 7 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22443

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Karl G. Kessler

2. Date of Death

Month Day Year
July 7, 1997

3. Time of Death

11:25 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

376-14-0086

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 22, 1919

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5927 Anniston Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

physicist

16b. Kind of Business/Industry

National Bureau of
Science and Technology

17. Father's Name (First, Middle, Last)

Gunther Kessler

18. Mother's Name (First, Middle, Maiden Surname)

Anna Schneider

19a. Informant's Name/Relationship (Type, Print)

Betty Kessler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5927 Anniston Road, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

7-9-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. DeL...

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Myocardial Infarction

Due to (or as a consequence of):

1 day

b. Forefoot Amputation

Due to (or as a consequence of):

3 weeks

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Arteriosclerosis

Due to (or as a consequence of):

30 years

d. Diabetes Insulin Dependant

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

James M. Salander, M.D.

29c. License number

D39064

29d. Date signed (Month, Day, Year)

July 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James M. Salander, M.D. 11119 Rockville Pike #204, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

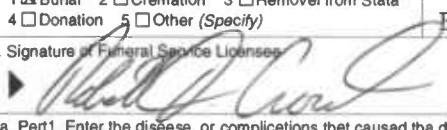
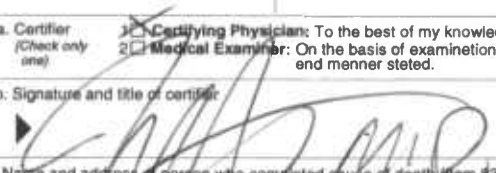
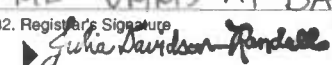
Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22444

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY L KELLUM | | | | | 2. Date of Death
Month JULY Day 9 Year 1997 | | 3. Time of Death
1539 | | |
| | 4a. Facility Name (If not institution, give street and number)
UMMS AT BALTIMORE | | | | | 4b. City, Town, or Location of Death
BALTIMORE, MD | | 4c. County of Death
BALTIMORE CITY | | |
| Funeral
Director | 5. Social Security Number
213-58-3028 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
44 Yrs. | | 8. Date of Birth (Month, Day, Year)
November 10, 1952 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Cecil | | 10c. City, Town or Location
Elkton | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
17 Manassas Drive | | | | | 10f. Zip Code
21921 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Shipping/Receiving Clerk | | | 16b. Kind of Business/Industry
Walk-in Freezer & Cooler company | | |
| 17. Father's Name (First, Middle, Last)
Delbert Atkinson, Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Doris Clayton | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Earl M. Kellum / Spouse | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17 Manassas Drive, Elkton, MD 21921 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethel Cemetery | | | Date
July 12 1997 | | 20c. Location - City or Town, State
North East, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Crouch Funeral Home
127 South Main Street, North East, MD 21901 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. Gastrointestinal bleeding
Due to (or as a consequence of): | | | | | | | | | | 48h |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Cirrhosis of liver
Due to (or as a consequence of): | | | | | | | | | | >6 months |
| c. _____
Due to (or as a consequence of): | | | | | | | | | | |
| d. _____
Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D47261 | | 29d. Date signed (Month, Day, Year)
JULY 9, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JEFF PLOTKIN, MD UMMS AT BALTIMORE | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 11 1997 | | | | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22445

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Billie Naomi Koznowsky

2. Date of Death

July 7, 1997

3. Time of Death

4:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3800 Matthews Dr.

4b. City, Town, or Location of Death

Temple Hills

4c. County of Death

Prince George's

5. Social Security Number

267-36-1948

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

3/5/30

9. Birthplace (State or Foreign Country)

Clinton, Arkansas

Usual Residence of Decedent

10a. State
Maryland10b. County
Prince George's10c. City, Town or Location
Temple Hills

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

3800 Matthews Dr.

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Raymond Sterlin

18. Mother's Name (First, Middle, Maiden Surname)

Louise Maudsley Slusher

19a. Informant's Name/Relationship (Type, Print)

Andrew Koznowsky/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery 7/10/97

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Nancy A. Dawson M.D.

29c. License number

MD D31586

29d. Date signed (Month, Day, Year)

July 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nancy A. Dawson, M.D. Walter Reed Army Hospital N.W. Washington, D.C.

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

John A. Dawson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

10:28 AM

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY Y. KAWAMURA

2. Date of Death

JULY 7, 1997

3. Time of Death

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

546-24-2995

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 18, 1919

9. Birthplace (State or Foreign Country)

CALIFORNIA

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

WHEATON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12827 HOLDRIDGE ROAD

10f. Zip Code

20906

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: JAPANESE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

2

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

RIKI MATSU KAWAMURA

18. Mother's Name (First, Middle, Maiden Surname)

TERU KAWAMURA

19e. Informant's Name/Relationship (Type, Print)

ALICE M. KAWAMURA, SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1401 BLAIR MILL ROAD, #308, SILVER SPRING, MD 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

7/11/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD., BRENTWOOD, MD 20722

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Acute Anterior Myocardial Infarction 6 days

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D25080

29d. Date signed (Month, Day, Year)

7/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Frank Gravano, MD, 10313 Georgia Ave, Silver Spring, MD

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22447

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
WILLIAM M. KING | | | | 2. Date of Death
Month 6 -Day 20 -Year 97 | | 3. Time of Death
1:30 PM | |
| 4a. Facility Name (If not institution, give street and number)
HEARTLAND HEALTH CARE CENTER | | | | 4b. City, Town, or Location of Death
HYATTSVILLE | | 4c. County of Death
P.G. | |
| 5. Social Security Number
577-84-8312 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
34 Yrs. | | 8. Date of Birth (Month, Day, Year)
8-5-1962 | |
| 9. Birthplace (State or Foreign Country)
VIRGINIA | | 10a. State
MD | | 10b. County
P.G. | | 10c. City, Town or Location
CAPITAL HEIGHTS | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
401 DATE LEAF AVENUE | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 1 YR College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DISABLED | | 16b. Kind of Business/Industry
None | | | |
| 17. Father's Name (First, Middle, Last)
WILLIAM GREENE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELLA L. KING | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ELLA L. GREENE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
401 DATE LEAF AVE. CAPITAL HEIGHTS, MD 20743 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
FT. LINCOLN CEMETERY | | 20c. Location - City or Town, State
6-30-97 BRENTWOOD, MD | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
AUSTIN ROYSTER FUNERAL HOME
3821 14TH ST. N.W. WASH. DC 20011 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CARDIO RESPIRATORY FAILURE
AIDS
SEIZURE DISORDER
TOXOPLASMOSIS | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
 MD | | 29c. License number
D42019 | | 29d. Date signed (Month, Day, Year)
JUNE 25TH 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IMRAN CHOWDHURY, M.D. 6500 RIGGS RD. HYATTS., MD 20783 | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 08 1997 | | | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

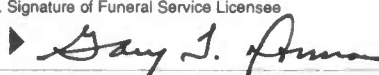
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22448

| | | | | | | | | |
|---|--|----------------------------------|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Wilbert Alfred Larson | | | | 2. Date of Death
Month July Day 1 Year 1997 | | 3. Time of Death
10:01am | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
017-24-5885 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
64 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 6, 1933 | |
| | | | | | | | 9. Birthplace (State or Foreign Country)
Massachusetts | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
2804 Strauss Terrace | | | | 10f. Zip Code
20904 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Systems Analyst | | 16b. Kind of Business/Industry
FAA | | |
| 17. Father's Name (First, Middle, Last)
Wilbert Alfred Larson, Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Heath | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Todd Larson / Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3803 Preserve Court, #207, Tampa, Florida 33624 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fairfax Crematory | | Date
7/6/97 | | 20c. Location - City or Town, State
Fairfax, Virginia | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Everly Funeral Home
10565 Main Street
Fairfax, Virginia 22030 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction
Due to (or as a consequence of):

b. Ruptured abdominal aortic aneurysm
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death

1 hr

2-3 hr |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how Injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D37929 | | 29d. Date signed (Month, Day, Year)
July 1, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
10810 Connecticut Ave. Kensington, Md. 20895 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 08 1997 | | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22449

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Francis V. LaRuffa

2. Date of Death

Month Day Year
June 27 1997

3. Time of Death

5:20 AM

4a. Facility Name (If not institution, give street and number)

19312 Treadway Road

4b. City, Town, or Location of Death

Brookeville

4c. County of Death

Montgomery

5. Social Security Number

137-32-9996

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 5, 1911

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Florida

10b. County

Palm Beach

10c. City, Town or Location

Hyland Beach

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2921 South Ocean Boulevard

10f. Zip Code

33487

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Attorney at Law

16b. Kind of Business/Industry

Legal

17. Father's Name (First, Middle, Last)

Agostino LaRuffa

18. Mother's Name (First, Middle, Maiden Surname)

Rosina Calabro

19a. Informant's Name/Relationship (Type, Print)

Francis V. LaRuffa, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19312 Treadway Road Brookeville, Maryland 20833

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Charles Cemetery

Date

7/01/97

20c. Location - City or Town, State

Pinelawn, New York

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Non small cell lung cancer

Due to (or as a consequence of):

Smear

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35635

29d. Date signed (Month, Day, Year)

June 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Karwan 1811 Prince Philip Dr. Olney, MD 20832

31. Date filed (Month, Day, Year)

JUL 01 1997

32. Registrar's Signature

John Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22450

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Chung-Pu Lee | | | | 2. Date of Death
Month Day Year
July 2, 1997 | | | | 3. Time of Death
7:51 PM | |
| | 4e. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
207-54-9395 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 12, 1906 | | 9. Birthplace (State or Foreign Country)
China | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | |
| To Be Completed by Funeral Director | 10e. Street and Number
8 Cedarwood Court | | | | 10f. Zip Code
20852 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Asian | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
- 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Head of Security | | | | 16b. Kind of Business/Industry
Electronics | |
| | 17. Father's Name (First, Middle, Last)
Feng-Lin Lee | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dong | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Marjorie Yeh/ Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 Cedarwood Court, Rockville, Maryland 20852 | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date
Montgomery Crematorium, Inc. July 3, 1997 | | | | 20c. Location - City or Town, State
Bethesda, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
[Signature] MD0689 | | | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue,
Rockville, Maryland 20850-2805 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Neutropenia
Due to (or as a consequence of):
Sepsis
Due to (or as a consequence of):
Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
2-3 Days
2-3 Days
2-3 Days | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Rectal Cancer | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
D37891 | |
| | 29d. Date signed (Month, Day, Year)
July 2, 1997 | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Amit Rajvanshi, M.D. 121 Congressional Lane, #409, Rockville, Maryland 20852 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 0 8 1997 | | | | 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22451

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FREDA G. LIGHT

2. Date of Death

Month Day Year
JULY 5, 1997

3. Time of Death

11:10AM

4a. Facility Name (If not institution, give street and number)

6111 MONTROSE RD., #903

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

083-01-4693

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
APR. 21, 1912

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6111 MONTROSE RD., #903

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSE WIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ISAAC GOLDING

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA

19a. Informant's Name/Relationship (Type, Print)

SHEVRA ZUCKER / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12813 HUNTSMAN WAY, POTOMAC, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

STAR OF DAVID MEM. GARD. 7/8/97

Date

20c. Location - City or Town, State

PAMPANO BEACH, FL

21. Signature of Funeral Service Licensee

DANIEL SIMONS

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RECURRENT GASTRIC CANCER

2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOSEPH HAGGERTY MD 9707 MEDICAL CENTER DR #300 ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

JUL 6 7 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22452

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Audrey V. Luosen Kamp

2. Date of Death

Month Day Year

3. Time of Death

7:10 PM

4e. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-18-8057

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sep. 9, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

810 Gist Avenue

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Lewis A. Burgess

18. Mother's Name (First, Middle, Maiden Surname)

Inez McNamara

19e. Informant's Name/Relationship (Type, Print)

Harry A. Leusenkamp

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

810 Gist Avenue Silver Spring, Maryland 20910

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

7/7/97 Brentwood, Maryland

21. Signature of Funeral Service Licensee

Tracy A. Shuman

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction 3 hrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Tauber MD

29c. License number

D08546

29d. Date signed (Month, Day, Year)

July 4 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Tauber 8218 Wisconsin Ave Bethesda

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

John Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22453

Certificate of Death

Reg. No.

| | | | | | |
|---|---|---------------------------------|--|--------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edward W. Legear | | 2. Date of Death
Month February Day 15 Year 1997 | | 3. Time of Death
0105 |
| | 4a. Facility Name (If not institution, give street and number)
HARFORD Mem. Hospital | | 4b. City, Town, or Location of Death
Harrode Grace | | 4c. County of Death
HARFORD |
| Funeral
Director | 5. Social Security Number
213-16-4488 | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
96 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Feb. 18, 1900 | | 9. Birthplace (State or Foreign Country)
MD | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
Harford |
| | 10c. City, Town or Location
Harrode Grace | | 10d. Inside City Limits
1 Yes 2 No | | |
| | 10e. Street and Number
519 LAFAYETTE ST. | | 10f. Zip Code
21078 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BALENDER |
| | 16b. Kind of Business/Industry | | 17. Father's Name (First, Middle, Last)
Thomas Legear | | 18. Mother's Name (First, Middle, Maiden Surname)
Angelene Harris |
| | 19a. Informant's Name/Relationship (Type, Print)
Ellen Hamilton - cousin | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
519 LAFAYETTE ST Harrode Grace, MD | | |
| | 20a. Method of Disposition
1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Cem. | | 20c. Location - City or Town, State
2-20-97 Baltimore, MD |
| | 21. Signature of Funeral Service Licensee
[Signature] | | 22. Name and Address of Facility
BEARD FUNERAL HOME
552 Lewis St. Harrode Grace, MD | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
old age, chr. Renal failure.
Diabetes mellitus uncontrolled | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 <input checked="" type="checkbox"/> No 3 Probably 4 Unknown | | | | | |
| 24a. Was an autopsy performed?
1 Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | | | | |
| 28a. Date of Injury (Month, Day, Year)
M | | | | | |
| 28b. Time of Injury
M | | | | | |
| 28c. Injury at Work?
1 Yes 2 No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
[Signature] MD | | | | | |
| 29c. License number
D 32609 | | | | | |
| 29d. Date signed (Month, Day, Year)
2/15/97 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kammiel Mulham MD. 703 Revolution St. Harrode Grace, MD 21078 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 26 1997 | | | | | |
| 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22454

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN WESTLEY LUMSDEN | | | | 2. Date of Death
Month Day Year
JULY 11, 1997 | | 3. Time of Death
14:40 | |
| | 4a. Facility Name (If not institution, give street and number)
WASHINGTON ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
TAKOMA PARK | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
578-01-5596 | | 6. Sex
1 <input type="checkbox"/> M 2 <input type="checkbox"/> F
X | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 17, 1909 | |
| | 9. Birthplace (State or Foreign Country)
ARKANSAS | | 10e. State
MARYLAND | | 10b. County
P.G. | | 10c. City, Town or Location
UPPER MARLBORO | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
14610 CAMBRIDGE DRIVE | | 10f. Zip Code
20772 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify:
WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8TH College (1-4 or 5+) | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HEAVY EQUIP. MANAGER | | 16b. Kind of Business/Industry
D.C. GOVT. (RET.) | | | |
| | 17. Father's Name (First, Middle, Last)
OMAR CLAYTON LUMSDEN | | 18. Mother's Name (First, Middle, Maiden Surname)
JOHN ETTA SMITH | | | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
ARTHUR DALE LUMSDEN | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3501 ASTORIA RD. KENSINGTON, MD. 20895 | | | | | |
| | 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
TRINITY MEMORIAL GARDEN 7-11-WALDORF, MARYLAND | | Date | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE
LA PLATA, MARYLAND 20646 | | | | | |
| | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. SEPSIS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death
~ 10 days | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D-17874 | | 29d. Date signed (Month, Day, Year)
7-11-97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
S.M. NAYAR, MD, 3717-38th AVE, COTTAGE CITY, MD 20722 | | 31. Date filed (Month, Day, Year)
JUL 14 1997 | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22455

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sharon

Loman

2. Date of Death

Month Day Year

July 7 1997

3. Time of Death

2:45AM

4a. Facility Name (If not institution, give street and number)

Mariner Health Care of Greater Laurel

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

220-90-9493

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

34

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 10, 1962

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10a. Street and Number

16 S. Patterson Park Ave.

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DD NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Vittorio James Vidi

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth C. LoBuono

19a. Informant's Name/Relationship (Type, Print)

Elizabeth C. Vidi/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6270 Edsall Rd. Alexandria, Va. 22312

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Washington Nat. Cemetery

Date

7/9/97

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Coma

Due to (or as a consequence of):

b.

Lithium Toxicity

Due to (or as a consequence of):

c.

Probable Chronic Lithium Toxicity

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

5 months

6 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recent profound hyponatremia.

Probable central pontine myelinolysis

Recent cardiac shock. Schizophrenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident
3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. N. Machirao ATTENDING

29c. License number

D16200

29d. Date signed (Month, Day, Year)

July 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. N. MACHIRAO 220-C MAIDEN CHOICE LA, CATONSVILLE, MD, 21228

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22456

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Francis Long

2. Date of Death

Month

Day

Year

JULY

7,

1997

3. Time of Death

10:35AM

4a. Facility Name (If not institution, give street and number)

Ravenwood Lutheran Village 1183 Luther Dr.

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

579-03-5721

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan, 29, 1907

9. Birthplace (State or Foreign Country)

Emmitsburg, Md.

Usual Residence of Decedent

10a. State

10b. County

Maryland Prince George's

10c. City, Town or Location

Ft. Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

21 East Arthur Dr.

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self-employed

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Charles E. Long

18. Mother's Name (First, Middle, Maiden Surname)

Mary Alice Slagel

19a. Informant's Name/Relationship (Type, Print)

Charles Michael Long/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2745 Berry Hills Rd. Waldorf, Md. 20603

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery 7/11/97

Date

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Aortic Stenosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William B. Kerns, MD 22911 Jefferson Blvd. Smithsburg, MD 21783

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22457

Amended #'s 4a. 10e. & 19b. P.G.C. 7/15/97 *ce* Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

William Anthony Lardner

2. Date of Death

Month
JulyDay
2,Year
1997

3. Time of Death

12:20 a.m.

4a. Facility Name (If not institution, give street and number)

4205
4502 Newton Street

4b. City, Town, or Location of Death

Colmar Manor

4c. County of Death

Prince George's

5. Social Security Number

579-48-1788

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 5, 1909

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

Maryland Prince George's

10b. County

10c. City, Town or Location

Colmar Manor

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4502 Newton Street
4205

10f. Zip Code

20722

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Engineer

16b. Kind of Business/Industry

Providence Hospital

17. Father's Name (First, Middle, Last)

John Lardner

18. Mother's Name (First, Middle, Maiden Surname)

Mary Gavin

19a. Informant's Name/Relationship (Type, Print)

Josephine H. Lardner - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4502 Newton Street, Colmar Manor, Maryland 20722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

07/05/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Francis Gasch - Trade

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dehydration/Malnutrition

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

b. Dementia, Mixed type

Due to (or as a consequence of):

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

s/p Cerebrovascular accident

Type II Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William J. Zepf M.D.

29c. License number

MD#D45719

29d. Date signed (Month, Day, Year)

7/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William J. Zepf M.D., 4151 Bladensburg Road, Colmar Manor, Maryland 20722

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

John Davidson Carroll

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22458

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|---------------------------------------|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Roland Marcealeas Lewis II | | | | 2. Date of Death
Month July Day 01 Year 1997 | | 3. Time of Death
6:42 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Prince George's Hospital | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
213-15-1722 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
10 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 2, 1987 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Hyattsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
4848 66th Avenue | | 10f. Zip Code
20784 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | 16b. Kind of Business/Industry
Private | | | |
| | 17. Father's Name (First, Middle, Last)
Roland Marcealeas Lewis | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Patricia Y. Mooney | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Patricia Y. Black/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4848 66th Avenue, Hyattsville, Maryland 20784 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. Location - City or Town, State
7/7/97 Brentwood, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
Nancy A. Percentie | | | | 22. Name and Address of Facility
J.B. Jenkins Funeral Home
7474 Landover Road, Landover, Maryland 20785 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Disease
Due to (or as a consequence of):

b. Tracheotomy
Due to (or as a consequence of):

c. Chronic lung and brain disease
Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Down Syndrome | | | | | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicida <input type="checkbox"/> Homicida | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Glen C. Rosenquist | | | | 29c. License number
D10,000 | | 29d. Date signed (Month, Day, Year)
7-3-97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Glen C. Rosenquist, M.D. Children's Nat'l Med Ctr, 111 Michigan Ave, NW DC 20010 | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JUL 07 1997 | | | | 32. Registrar's Signature
John A. Russell | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22459

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Xavier M. Meltzer

2. Date of Death

Month
July

Day

8, 1997

Year

3. Time of Death

6:00pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8103 Hampden Lane

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

578-05-0763

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 20, 1912 Washington, D.C.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

8103 Hampden Lane

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

H.E.W.

17. Father's Name (First, Middle, Last)

Charles Schrader

16. Mother's Name (First, Middle, Maiden Surname)

Magdaline Darcey

19a. Informant's Name/Relationship (Type, Print)

Theodore H. Meltzer/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10a - 10f

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington National Cemetery

Date

7/10/97

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Homes 22046
472 N. Washington St. Falls Church, VA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE SMALL STROKES

Due to (or as a consequence of):

b. Cerebral Arteriosclerosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hr

3-4 hr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MACULAR DEGENERATION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09470

29d. Date signed (Month, Day, Year)

July 8, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Eugene P. Libre 10400 Conn. Avenue #606, Kensington, MD 20895-3910

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

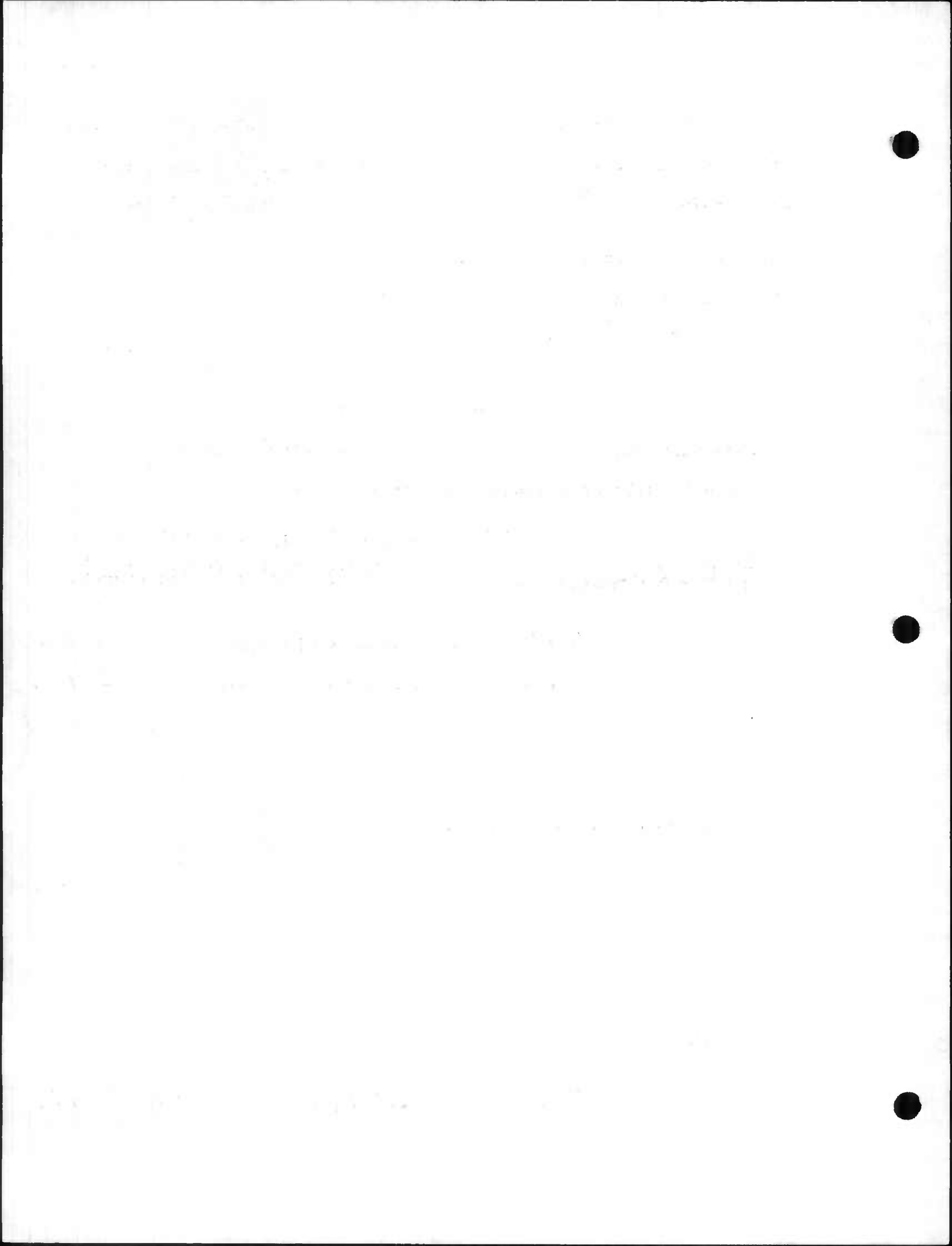
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22460

Item:11 per FH G-750 8/8/97 dh

Certificate of Death

Reg. No.

| | | | | | | | | | |
|-------------------------------------|--|--|--|--|--|--------------------------------|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Henry Michelson | | | | 2. Date of Death
Month July Day 7 Year 1997 | | 3. Time of Death
1:30 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
155-36-8097 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 3, 1909 | | |
| | 9. Birthplace (State or Foreign Country)
New York | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | | |
| | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
5913 Welborn Drive | | | | 10f. Zip Code
20816 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 + Collega (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Physician | | 16b. Kind of Business/Industry
Medicine | | |
| | 17. Father's Name (First, Middle, Last)
Max Michelson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Erna Rubenstein | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Janet M. Read - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5913 Welborn Drive Bethesda, MD 20816 | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Comfort Crematory | | Date
7/8/97 | | 20c. Location - City or Town, State
Alexandria, Virginia | | |
| | 21. Signature of Funeral Service Licensee
<i>Henry Peters</i> | | | | 22. Name and Address of Facility
Joseph Gawler's Sons
5130 Wisc. Ave. N.W. Washington, D. C. 20016 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
MALNUTRITION
Due to (or as a consequence of):
DEHYDRATION
Due to (or as a consequence of):
POOR ORAL INTAKE
Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPADRENALCORTICALISM, SINUSITIS, PNEUMONITIS, HYPERTENSION, TYPE II DIABETES | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 26. Place of Death (Check only one)
<input checked="" type="checkbox"/> Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| | 29b. Signature and title of certifier
<i>John Davidson-Rendell</i> | | | | 29c. License number
D35370 | | 29d. Date signed (Month, Day, Year)
07 JUL 1997 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JOHN DAVIDSON-RENDALL, MD ROCKVILLE, MD 20852 | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUL 11 1997 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22461

| | | | | | | | | | | |
|---|---|--|---|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BENJAMIN (NMN) MILLER | | | | 2. Date of Death
Month JUNE Day 18 Year 1997 | | | | 3. Time of Death
0731 | |
| | 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
NONE | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. | | 8. Date of Birth (Month, Day, Year)
05 JUNE 18, 1997 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | 10a. State
MARYLAND | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
GAITHERSBURG | |
| To Be Completed by Funeral Director | 10e. Street and Number
12117 PUEBLO ROAD | | | | 10f. Zip Code
20878 | | 10g. Citizen of What Country?
UNITED STATES | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) _____ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NONE | | | 16b. Kind of Business/Industry
NONE | | | | |
| | 17. Father's Name (First, Middle, Last)
WILLIS CHRISTOPHER MILLER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH GUZMAN | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
W. CHRISTOPHER MILLER, FATHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12117 PUEBLO ROAD, GAITHERSBURG, MD 20878 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY | | Date
JUNE 20, 1997 | | 20c. Location - City or Town, State
ALEXANDRIA, VIRGINIA | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
DEVOL FUNERAL HOME
10 EAST DEER PARK DR., GAITHERSBURG, MD 20877 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. PREMATUREITY
Due to (or as a consequence of):
b. GESTATIONAL AGE -- 19 Weeks
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
D38315 | | 29d. Date signed (Month, Day, Year)
JUNE 18, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID ZUCKERMAN, MD 9711 MEDICAL CENTER DR., ROCKVILLE, MD 20850 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JUN 25 1997 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

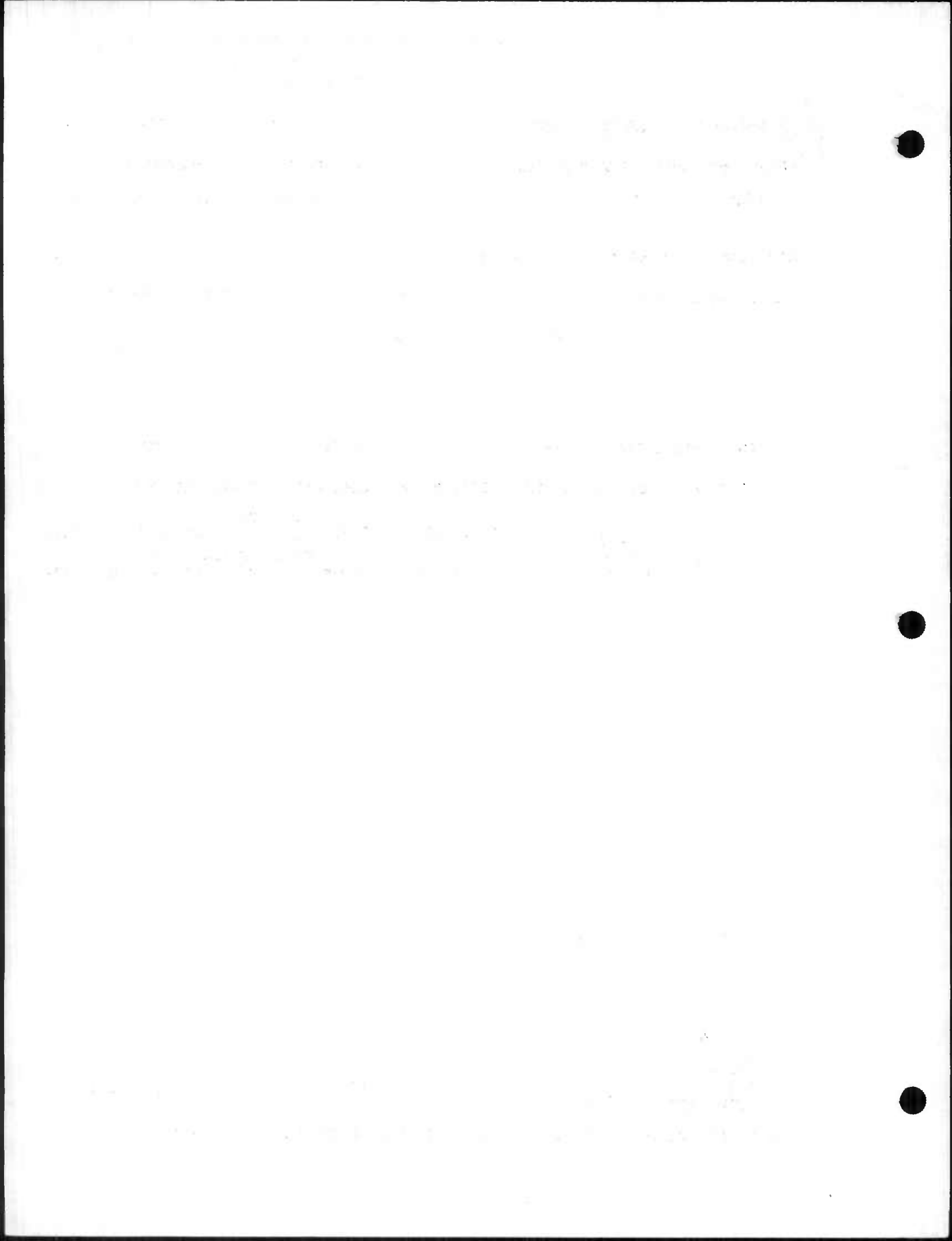
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22462

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
ExaminerFuneral
Director

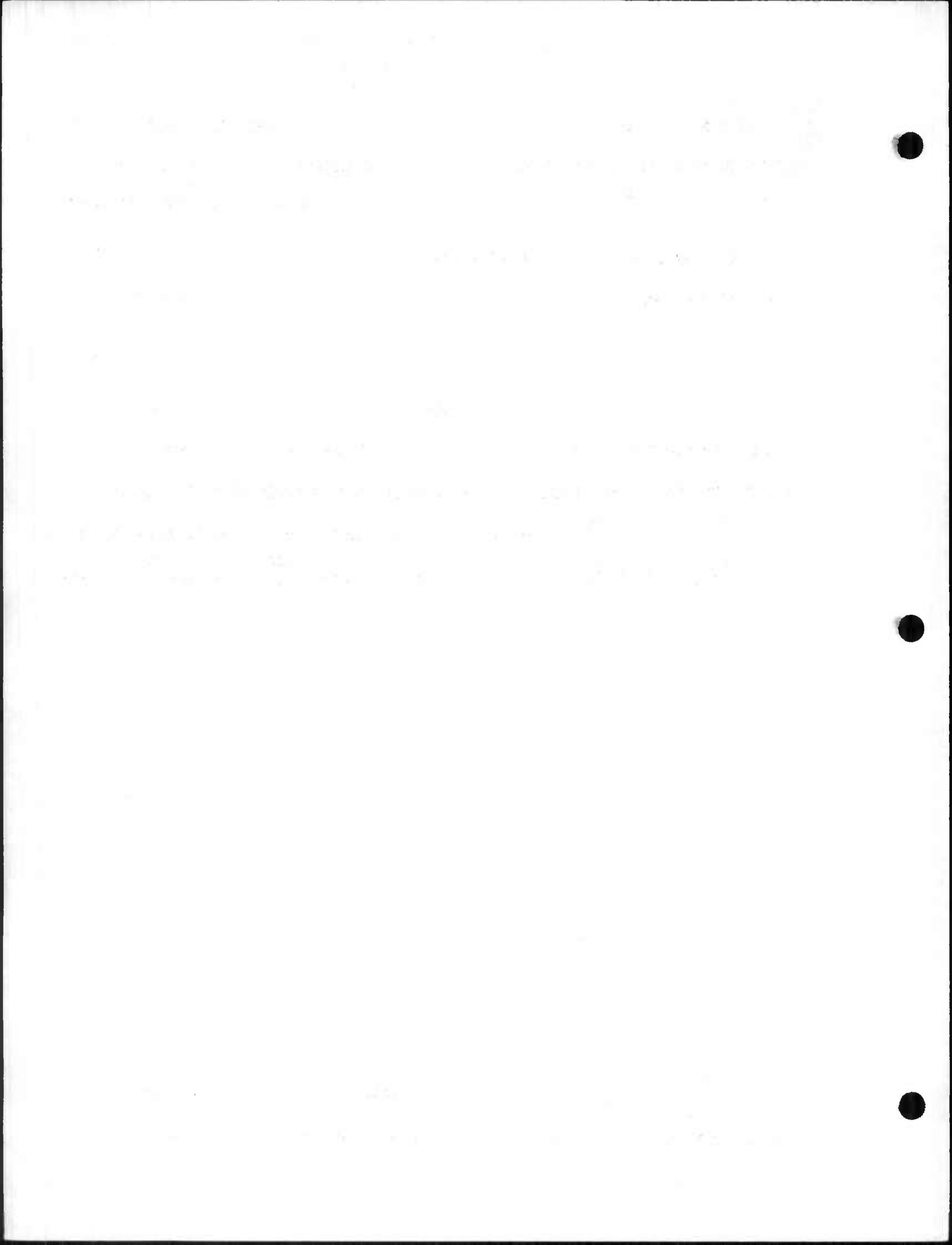
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
JOSHUA (NMN) MILLER | | 2. Date of Death
Month Day Year
JUNE 18, 1997 | | 3. Time of Death
0812 | |
| 4a. Facility Name (If not Institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY |
| 5. Social Security Number
NONE | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
Yrs.
05 | If Under 1 Year
Months Days
05 | 8. Date of Birth (Month, Day, Year)
JUNE 18, 1997 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| Usual Residence of Decedent | | | | | |
| 10a. State
MARYLAND | 10b. County
MONTGOMERY | 10c. City, Town or Location
GAITHERSBURG | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
12117 PUEBLO ROAD | | 10f. Zip Code
20878 | | 10g. Citizen of What Country?
UNITED STATES | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify:
WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) NONE | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NONE | | 16b. Kind of Business/Industry
NONE | | | |
| 17. Father's Name (First, Middle, Last)
WILLIS CHRISTOPHER MILLER | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH GUZMAN | | |
| 19a. Informant's Name/Relationship (Type, Print)
W. CHRISTOPHER MILLER, FATHER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12117 PUEBLO ROAD, GAITHERSBURG, MD 20878 | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY | | 20c. Location - City or Town, State
ALEXANDRIA, VIRGINIA | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
DEVOL FUNERAL HOME
10 EAST DEER PARK DR., GAITHERSBURG, MD 20877 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. PREMATURITY
Due to (or as a consequence of):
b. GESTATIONAL AGE -- 19 Weeks
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | Approximate Interval Between Onset and Death
MINUTES |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D38315 | | 29d. Date signed (Month, Day, Year)
JUNE 18, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID ZUCKERMAN, MD 9711 MEDICAL CENTER DR., ROCKVILLE, MD 20850 | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 25 1997 | | 32. Registrar's Signature
 | | | |

State
Registrar



WRC
97-3219-031
SERONA
MOSBY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22463

Items: 23a part I, 27, 28a-f per MEO G-749 7/29/97 dh

| | | | | | | |
|---|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SERONA MOSBY | | 2. Date of Death
Month Day Year
JUNE 12, 1997 | | 3. Time of Death
12:56 PM | |
| | 4a. Facility Name (If not institution, give street and number)
19648 WHITE SADDLE DR. | | 4b. City, Town, or Location of Death
GERMANTOWN | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
577-94-3852 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
35 Yrs. | |
| | 8. Date of Birth (Month, Day, Year)
Feb 4, 1962 | | 9. Birthplace (State or Foreign Country)
Washington, DC | | | |
| Usual Residence of Decedent | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Germantown | | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 10e. Street and Number
19648 White Saddle Drive | | 10f. Zip Code
20874 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Entertainer | | 16b. Kind of Business/Industry
Musical | | |
| 17. Father's Name (First, Middle, Last)
James Little | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Little | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Fred B. Mosby, Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19648 White Saddle Drive, Germantown, MD 20874 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Washington National Cem. | | 20c. Location - City or Town, State
June 20, Suitland, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
DeVol Funeral Home
10 East Deer Park Dr., Gaithersburg, MD 20877 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. DIPHENHYDRAMINE INTOXICATION COMPLICATED BY DROWNING
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
found 6/12/97 | | 28b. Time of Injury
found: 10:20 | | |
| | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
unknown | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
found in bathtub at home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
19648 White Saddle Dr. Germantown, Maryland | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
JUNE 13, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARGARET A. KOWALSKA 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| 31. Date filed (Month, Day, Year)
JUN 25 1997 | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22464

Reg. No.

**Physician
/Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)
Hilda Lupita Mudd | | | | 2. Date of Death
Month: July Day: 9 Year: 1997 | | 3. Time of Death
12:15 AM | |
| 4a. Facility Name (If not institution, give street and number)
Springbrook Adventist Nursing Home | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| 5. Social Security Number
579-40-5488 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months: Days: Hours: Min. | 8. Date of Birth (Month, Day, Year)
July 19, 1910 | | 9. Birthplace (State or Foreign Country)
Ireland |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
2201 Colston Drive, Apt. 405 | | | | 10f. Zip Code
20910 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 College (1-4 or 5+): | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | |
| 17. Father's Name (First, Middle, Last)
James O'Connor | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rose White | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Rev. John J. Mudd | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4300 Harewood Road, NE, Washington, DC 20017 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | Date
7/12/97 | | 20c. Location - City or Town, State
Silver Spring, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. Cardio pulmonary arrest | | | | | Approximate Interval Between Onset and Death
4 Min. |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Due to (or as a consequence of): | | | | | |
| | | b. Cardiac arrhythmia | | | | | 4 Min. |
| | | Due to (or as a consequence of): | | | | | |
| | | c. Congestive heart failure | | | | | 2 Years |
| | | Due to (or as a consequence of): | | | | | |
| | | d. Coronary Artery Disease | | | | | 10 Years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D22309 | | 29d. Date signed (Month, Day, Year)
July 10th, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Phillip W. Poth 831 University Blvd. East Suite 32, Silver Spring, MD 20903 | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 11 1997 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**State
Registrar**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22465

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSALIE

MURNAN

2. Date of Death

July 2 1997

Day Year

3. Time of Death

10:50 PM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

293-20-5353

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR 22, 1925

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14114 LONDON LANE

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

DALE WRIGHT

18. Mother's Name (First, Middle, Maiden Surname)

JESSIE SMITH

19a. Informant's Name/Relationship (Type, Print)

MICHELE R. NIEFELD DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3808 MISTY HOLLOW ROAD, POINT OF ROCKS, MD 21777

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CREMOTORY

Date

JULY 4, 1997

20c. Location - City or Town, State

ALEXANDRIA, VA

21. Signature of Funeral Service Licensee

Tracy A. Shaver

22. Name and Address of Facility

Francis J. Collins Funeral Home
500 University Blvd. West
Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

HEPATIC FAILURE

Due to (or as a consequence of):

Biliary obstruction

Due to (or as a consequence of):

Colorectal cancer

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2 M

6 M

1 YR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

N.A.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Edgar H. Lewis

29c. License number

D10682

29d. Date signed (Month, Day, Year)

July 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDGAR H. LEWIS, 984 GEORGIA AVE.

31. Date filed (Month, Day, Year)

JUL 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22466

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Brian Kipkorir Mutai

2. Date of Death

Month Day Year
June 11, 1997

3. Time of Death

6:23 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

none

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 9, 1997

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2415 Ross Road, #202

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
noneCollege (1-4 or 5+)
none

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

infant

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

Andrew Suge

18. Mother's Name (First, Middle, Maiden Surname)

Cheryl Mutai

19. Informant's Name/Relationship (Type, Print)

Andrew Suge

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2415 Ross Road, #202, Silver Spring, Maryland 20910

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven

Date

6-18-97 Silver Spring, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Carol A. Dehm

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple Organ Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Respiratory Failure

Due to (or as a consequence of):

2 days

c. Extreme Immaturity

Due to (or as a consequence of):

2 days

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Matthew Picard MD

29c. License number

D 50522

29d. Date signed (Month, Day, Year)

June 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Matthew Picard MD, 1500 Forest Glen Rd, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

JUN 20 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22467

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL F. McNULTY

2. Date of Death

FOUND
Day
JULY 4, 1997

3. Time of Death

2:55 PM
FOUND

4a. Facility Name (If not institution, give street and number)

73 H RIDGE RD.

4b. City, Town, or Location of Death

GREENBELT

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

052-38-0931

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 2, 1946

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

GREENBELT

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

73 H RIDGE RD.

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1965-1985

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STORE KEEPER

16b. Kind of Business/Industry

U.S. NAVY

17. Father's Name (First, Middle, Last)

FRANCIS

McNULTY

18. Mother's Name (First, Middle, Maiden Surname)

MADELINE

BOENIG

19a. Informant's Name/Relationship (Type, Print)

BERNARDINE ABELL McNULTY/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NATIONAL CEM. 7/10/97

Date

20c. Location - City or Town, State

ARLINGTON, VA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

W. W. Chambers

M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ETHANOL ABUSE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33954

29d. Date signed (Month, Day, Year)

JULY 08, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARCO F. GILLES JR MD, 3001 HOSPITAL PRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #20a, 7/8/97, BMW, Montg. Co.

Certificate of Death

Reg. No.

22468

| | | | | | | | | |
|--|---|---|--|---|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Glenn McLaughlin | | | | 2. Date of Death
Month June Day 28 , Year 1997 | | 3. Time of Death
10:25 am | |
| | 4a. Facility Name (If not institution, give street and number)
Manor Care Wheaton, Nursing Home | | | | 4b. City, Town, or Location of Death
Wheaton | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
579-50-0699 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
92 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
July 4, 1904 | 9. Birthplace (State or Foreign Country)
Prague, OK | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
D.C. | | 10b. County
N/A | | 10c. City, Town or Location
Washington, D.C. | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
3001 Veazey Terrace | | | | 10f. Zip Code
20008 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Economist | | | 16b. Kind of Business/Industry
U.S. Government | |
| 17. Father's Name (First, Middle, Last)
Claude E. McLaughlin | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Maude Thompson | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Dorothy J. McLaughlin Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3001 Veazey Terrace, N.W., Washington, D.C. 20008 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Comfort Crematory | | Date
7/1/97 | | 20c. Location - City or Town, State
Alexandria, Virginia |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Joseph Gawler's Sons Inc. 5130 WI Ave. NW Washington, D.C. 20016 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
1 day |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D 42518 | | 29d. Date signed (Month, Day, Year)
June 30, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gul Chablani, MD, 1111 Rockville Pike, #316, Rockville, MD 20852 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 07 1997 | | | | 32. Registrar's Signature
 | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

22469

ITEM: 1 per M.D. G-750 8-1-97 eoh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mattingly, John

JOHN P. MATTINGLY

2. Date of Death

Month Day Year

07 06 97

3. Time of Death

12:48 pm

4a. Facility Name (If not institution, give street and number)

Manor Care Silver Spring

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

379-26-5758

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

March 19, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

10 Yes XX No

10e. Street and Number

4100 Sellman Road

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes XX No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes XX No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Agricultural Scientist

16b. Kind of Business/Industry

University of Maryland

17. Father's Name (First, Middle, Last)

Raphael Douglas Mattingly

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Armour Fanning

19a. Informant's Name/Relationship (Type, Print)

Bonnie Mattingly (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

XX Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Linclon Cemetery 7/9/1997

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 week

Sequently list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Amyotrophic Lateral Sclerosis

Due to (or as a consequence of):

7 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Non-Insulin Dependent Diabetes

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably XX Unknown

24a. Was an autopsy
performed?

10 Yes XX No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes XX No

25. Was case referred to medical
examiner?

10 Yes XX No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural
20 Accident
30 Suicide
40 Homicide50 Pending
investigation
60 Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?

10 Yes XX No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Hargous

29c. License number

D25430

29d. Date signed (Month, Day, Year)

7/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Hargous 14333 Laurel Bowie Rd #307 Laurel, MD 20708

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

per M.D. G-750 8-1-97 eoh

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22470

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jerome S. Machlin

2. Date of Death

Month Day Year
July 2, 1997

3. Time of Death

6:00am

4a. Facility Name (If not institution, give street and number)

Manor Care of Wheaton

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

064-16-9128

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Nov. 11, 1913

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3615 Janet Road

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

National Director

16b. Kind of Business/Industry

American Contract
Bridge League

17. Father's Name (First, Middle, Last)

Jacob Machlin

18. Mother's Name (First, Middle, Maiden Summa)

Sadie Sobel

19a. Informant's Name/Relationship (Type, Print)

Gertrude Machlin-spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3615 Janet Rd Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Menorah Gardens

Date

7/3/97

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Edward Sagel Funeral Direction
1091 Rockville Pike, Rockville MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

End Stage Renal Disease

a. Due to (or as a consequence of):

Hypertension

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Chronic Obstructive Pulmonary Disease

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20367

29d. Date signed (Month, Day, Year)

July 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Joel Kalman 6111 Executive Blvd Rockville MD 20852

31. Date Filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

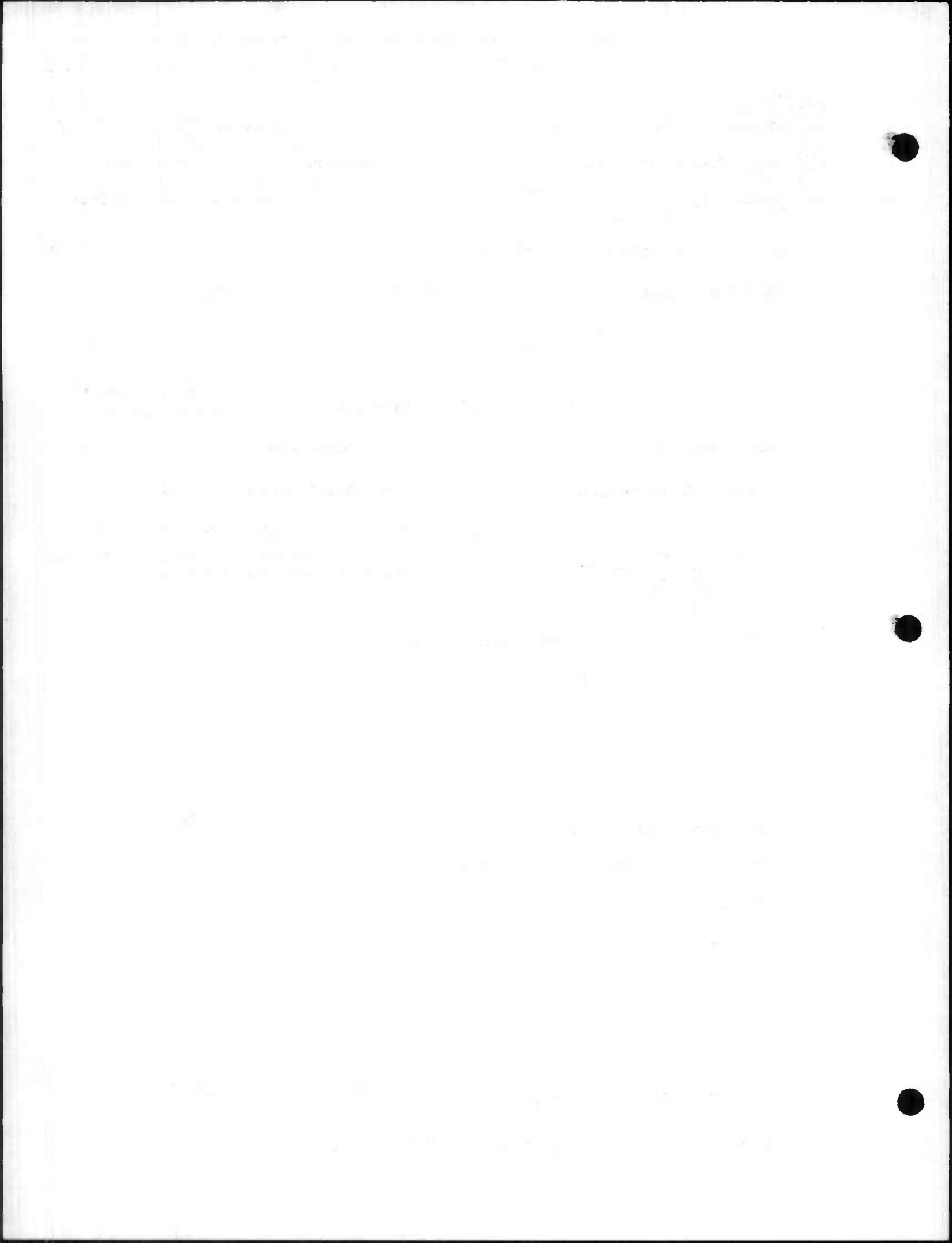
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22471

| | | | | | | | | |
|---|--|---|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joan T. Maiolo | | | | 2. Date of Death
Month Day Year
JULY 06 1997 | | 3. Time of Death
3:40 A | |
| | 4a. Facility Name (If not institution, give street and number)
MARYLAND SHOCK TRAUMA | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
217-32-0373 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 28, 1935 | |
| | 9. Birthplace (State or Foreign Country)
Washington, DC | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Severn | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
8239 Deerfield Circle | | 10f. Zip Code
21144 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Quest Diagnosis | | | | |
| 17. Father's Name (First, Middle, Last)
Robert G. Temple | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Clare L. Love | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Margaret A. Gatley | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
216 Ferndale Drive, Glen Burnie, MD 21061 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | 20c. Location - City or Town, State
7/9/97 Silver Spring, MD | | | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Stabs and Cutting Wounds.
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> XDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
7-6-97 | | 28b. Time of Injury
0131 M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred
subject stabbed | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Residence | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
8239 Deerfield Cir. | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
JULY 06, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 08 1997 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William F. Marks

2. Date of Death

Month Day Year
July 6, 1997

3. Time of Death

2:25 AM

4a. Facility Name (If not institution, give street and number)

1 Lee Court

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

102-22-9493

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
October 4, 1929

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1 Lee Court

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1951-1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Personnel Specialist

16b. Kind of Business/Industry

U.S. Public Health Service

17. Father's Name (First, Middle, Last)

Thomas Marks

18. Mother's Name (First, Middle, Maiden Surname)

Anastasia Higgins

19a. Informant's Name/Relationship (Type, Print)

Teresa M. Burleson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13808 Baywind Court, Silver Spring, Maryland 20905

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

7-6-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Delm

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home

26. Place of Death (Check only one)

5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George A. Sotos

29c. License number

D43083

29d. Date signed (Month, Day, Year)

July 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George A. Sotos, M.D., 9707 Medical Center Drive #300, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22473
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS CHARLES MURRAY

2. Date of Death

Month Day Year June 25 1997

3. Time of Death
3:25 PM

4a. Facility Name (If not institution, give street and number)

Shock Trauma Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

--

Funeral
Director

5. Social Security Number

219-56-2671

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 20, 1950 Pennsylvania

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

--

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1101 St. Paul Street

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Systems Analyst

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Thomas Walls Murray

18. Mother's Name (First, Middle, Maiden Surname)

Betty Jane Smith

19a. Informant's Name/Relationship (Type, Print)

Betty J. Murray, mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 F. Donzen Drive, Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Johns Catholic Church Cem.

Date 6/28/97

20c. Location - City or Town, State

Long Green, Maryland

21. Signature of Funeral Service Licensee

John K. McComas

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

15 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Brain Edema

Due to (or as a consequence of):

4 days

c. Multiple Cerebral Contusions

Due to (or as a consequence of):

5 days

d. Fall

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation

2 ☒ Accident

3 ☐ Suicide

4 ☐ Homicide

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

6-20-97

28b. Time of Injury

UNK M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject fell down stairs

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

51 Sussex Ave, Redbank Beach, Delaware

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John S. Britten, MD

29c. License number

D-22260

29d. Date signed (Month, Day, Year)

6/25/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOHN S. BRITTEN, MD; 22 S. GREENE ST., BALTIMORE, MARYLAND 21201

31. Date filed (Month, Day, Year)

6/25/JUN 27 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22474

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Norma L

2. Date of Death

Month Day Year

July 9, 1997

3. Time of Death

6:35pm

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

579-05-0384

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 25, 1920

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3705 Donnell Drive Apt 102

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

Federal Reserve Board

17. Father's Name (First, Middle, Last)

Hamett

Ghee

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Regal

19a. Informant's Name/Relationship (Type, Print)

James Miller (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3705 Donnell Dr. Apt 102 Forestville, Maryland 20747

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory

Date

July 11, 1997

20c. Location - City or Town, State

Clinton Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Rd Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *emphysema*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *cardiac arrhythmia*
Due to (or as a consequence of):

years

c. *congestive heart failure*
Due to (or as a consequence of):

months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

039691

29d. Date signed (Month, Day, Year)

7/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. REDJAE 4467 Old BRANCH AVE TEMPLE HILLS MD

State Registrar

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22475

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RETHA MILLIE MAYS

2. Date of Death

Month

Day

Year

July

05, 1997

3. Time of Death

4:15 A.M.

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

213-20-8032

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 10, 1925

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

819 Walters Mill Road

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William McKinley Bedsaul

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Bessie Greene

19a. Informant's Name/Relationship (Type, Print)

Robert R. Mays, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

819 Walters Mill Road, Forest Hill, Maryland 21050

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

7/8/97

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

50 West Broadway Street, Bel Air, Maryland 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. OVARIAN CANCER

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

231775

29d. Date signed (Month, Day, Year)

July 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN P. EDWARDS, MD

2112 BELAIR ROAD
FALLSTON, MARYLAND 21047

31. Date filed (Month, Day, Year)

JUL 7 1997

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Retha Millie Mays
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 22476

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
JOHN EDWARD MORGAN | | | | 2. Date of Death
Month JULY Day 10 Year 97 | | 3. Time of Death
2:55 PM | |
| 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital Clinton | | | | 4b. City, Town, or Location of Death
Clinton | | 4c. County of Death
Prince George's | |
| 5. Social Security Number
233-46-0974 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
APRIL 26, 1924 | |
| 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
CHARLES | | 10c. City, Town or Location
LA PLATA | | 10d. Inside City Limits
1 Yes 2 No | |
| 10e. Street and Number
9454 SILVER OAK ROAD | | | | 10f. Zip Code
20646 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: 1942-1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5 | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CHEMIST | | 16b. Kind of Business/Industry
U. S. GOVERNMENT | |
| 17. Father's Name (First, Middle, Last)
GRADY VEER MORGAN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LULA ANN THOMAS | | | |
| 19e. Intorment's Name/Relationship (Type, Print)
ELIZABETH ANN MORGAN/SPOUSE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9454 SILVER OAK ROAD, LA PLATA, MARYLAND 20646 | | | |
| 20e. Method of Disposition
1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HUNTT CREMATORY | | Data
7/11/1997 | | 20c. Location - City or Town, State
WALDORF, MARYLAND | |
| 21. Signature of Funeral Service Licensee
JPK Mark G. Brohawn M00053 | | | | 22. Name and Address of Facility
THE HUNTT FUNERAL HOME, INC., P.O. BOX 156, WALDORF, MARYLAND 20604 | | | |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Adenocarcinoma to LIVER
Due to (or as a consequence of):
b. Acute RENAL FAILURE
Due to (or as a consequence of):
c. Pseudomembranous Colitis
Due to (or as a consequence of):
d. Recurrent CARCINOMA of Prostate.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| Approximate Interval Between Onset and Death | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | |
| | | | | | | 24e. Was an autopsy performed?
1 Yes 2 No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
R. A. McConaughy MD | | | | 29c. License number
D07287 | | 29d. Date signed (Month, Day, Year)
July 11, 97 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
R. A. McCONAUGHY MD 1418 LIVINGSTON RD. FORT WASHINGTON, MD. 20744 | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 15 1997 | | 32. Registrar's Signature
John Davidson Randall | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lelia Morsberger

2. Date of Death

Month July Day 13 Year 1997

3. Time of Death

1:35 PM

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-56-4365

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

06-01-1928

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

HARMANS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1177 DORSEY ROAD

10f. Zip Code

21077

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

OGLE

MARBURY

CLARK

18. Mother's Name (First, Middle, Maiden Surname)

AMY

MARIE

PHELPS

19a. Informant's Name/Relationship (Type, Print)

(HUSBAND)

WILLIAM FRANCIS MORSBERGER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1177 DORSEY ROAD, HARMANS, MARYLAND 21077

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK

Date

7/17/97

20c. Location - City or Town, State

ELKRIDGE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

b.

Squamous Carcinoma of lung

Due to (or as a consequence of):

2 years

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

House Officer

29c. License number

AS2441614-45

29d. Date signed (Month, Day, Year)

July 13 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

XIAO M ZHOU 3001 S. Hanover St. Baltimore MD 21225

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22478

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Compton V. Moore

2. Date of Death

Month Day Year
JULY 07, 1997

3. Time of Death

1925PM

4e. Facility Name (If not institution, give street and number)

6806 ELBROOK ROAD

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

065-42-8761

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

05-20-30

9. Birthplace (State or Foreign Country)

Guyana

Georgetown,

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6806 Elbrook Road

10f. Zip Code

20706

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Printer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Joseph Nathaniel Moore

18. Mother's Name (First, Middle, Maiden Surname)

Ruby Anne Nicholas

19a. Informant's Name/Relationship (Type, Print)

Evdne Moore/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6806 Elbrook Road, Lanham, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Memorial Park

Date

7/12/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intra-abdominal gunshot wound

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

Final 7/7/97

28b. Time of Injury

1920Hr

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

home

28d. Describe how injury occurred

Subject shot self

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6806 Elbrook Road

Lanham Maryland

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 08, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22479

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Philip J. Murphy

2. Date of Death

Month Day Year
July 4 1997

3. Time of Death

11:50 P.M.

4a. Facility Name (If not institution, give street and number)

Gladys Spellman Nursing Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

175 14 1129

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 4, 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

15102 Nashua Lane

10f. Zip Code

20716

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: 41-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Pipefitter

16b. Kind of Business/Industry

Washington

Terminal Co.

17. Father's Name (First, Middle, Last)

John T. Murphy

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Delaney

19a. Informant's Name/Relationship (Type, Print)

Gertrude I. Murphy Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15102 Nashua Lane Bowie Maryland 20716

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

July 9, 1997

20c. Location - City or Town, State

Crownsville Maryland

21. Signature of Funeral Service Licensee

Robert E. Evans Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. ALZHEIMER'S DEMENTIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

TYPE 2 DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending☐ Investigation☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

28d. Describe how injury occurred

☐ Yes ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Henri DeLa Baume MD.

29c. License number

MD D 31498

29d. Date signed (Month, Day, Year)

JUL 5, 1997

30. Name and address of person who completed causa of death (Item 23e) (Type, Print)

HENRI DELA BAUME, M.D.

4000 MITCHVILLE RD. BOWIE, MD.

31. Date filed (Month, Day, Year)

JUL 11 1997

32. Registrar's Signature

John D. ...

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

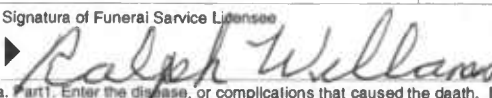
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

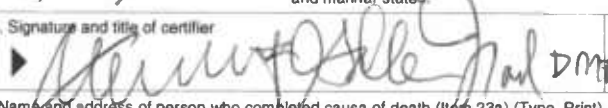
Certificate of Death

Reg. No.

97 22480

| | | | | | | | | |
|---|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EARNEST FREEDOM MOBLEY | | | | 2. Date of Death
Month JUNE Day 30 Year 1997 | | 3. Time of Death
06:45AM | |
| | 4a. Facility Name (If not institution, give street and number)
3901 SUITLAND ROAD | | | | 4b. City, Town, or Location of Death
SUITLAND | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
243 66 0266 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
52 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
APR 24, 1945 | 9. Birthplace (State or Foreign Country)
NORTH CAROLINA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
SUITLAND, MARYLAND | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
3901 SUITLAND ROAD #302 | | | | 10f. Zip Code | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1969- | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ENGINEER | | 16b. Kind of Business/Industry
MAINTENANCE | | |
| 17. Father's Name (First, Middle, Last)
ROBERT MOBLEY | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
VIOLA BUFFERT | | | |
| 19a. Informant's Name/Relationship (Type, Print)
THOMASINA MOBLEY (WIFE) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3901 SUITLAND RD. SUITLAND, MD | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MARYLAND VETERAN | | 20c. Location - City or Town, State
JULY 7, 1997 CHELTENHAM, MD | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
RALPH WILLIAMS FUNERAL SVC
517 11th STREET S. | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COLON CANCER | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 DME | | | | | 29c. License number
D-33954 | | 29d. Date signed (Month, Day, Year)
JUNE 30, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 07 1997 | | | | | | | | 32. Registrar's Signature
 |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 22481**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leonard M. Nelson

2. Date of Death

Month Day Year
July 5, 1997

3. Time of Death

11:05 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Brooke Grove Rehabilitation and Nursing Center

4b. City, Town, or Location of Death

Sandy Spring

4c. County of Death

Montgomery

5. Social Security Number

479-36-1756

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 14, 1939

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Brookeville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

22611 Georgia Avenue

10f. Zip Code

20833

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager/Sales

16b. Kind of Business/Industry

Lumber Yards

17. Father's Name (First, Middle, Last)

Calvin G. Nelson

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Harper

19a. Informant's Name/Relationship (Type, Print)

Bryant W. Nelson / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11102 Rock Road, Rockville, Maryland 20852

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

7-6-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Selman

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

b. Dysphagia

Due to (or as a consequence of):

c. Small Cell Cancer of the Lung

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

hours

days

one year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

STAFF PHYSICIAN

29c. License number

D42046

29d. Date signed (Month, Day, Year)

July 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grace Brooke Huffman, M.D., 18100 Slade School Road, Sandy Spring, Maryland 20860

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22482

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

John Hedden Nowalk

2. Date of Death

Month Day Year
July 4 1997

3. Time of Death

8:27 PM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

150 26 4350

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7-26-1932

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

MD

10b. County

AA

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

217 Mckeon Rd

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: Korean13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

QUALITY ASSURANCE

16b. Kind of Business/Industry

GOVT. PRINTING

17. Father's Name (First, Middle, Last)

JOHN F. NOWALK

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED HEDDEN

19a. Informant's Name/Relationship (Type, Print)

DOROTHY NOWALK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Met. CREMATORY

Date

7-9-97 Catonsville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert B. B...

22. Name and Address of Facility

BARRANCO AND SONS FUNERAL HOME
495 Ritchie Ave Severna Park, MD 2114623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Decompensation

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

30 minutes

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Hypoxia

Due to (or as a consequence of):

Unknown

c. Pulmonary edema

Due to (or as a consequence of):

Unknown

d. Cardiac Dysfunction

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Douglas N. Miniati

29c. License number

P10353

29d. Date signed (Month, Day, Year)

July 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Douglas N. Miniati, MD 22 South Queen St, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation $f(x) = \int_0^x f(t) dt$. It is shown that $f(x)$ is a constant function, and its value is determined by the initial condition $f(0) = 1$.

2. In the second part, we consider the function $g(x)$ defined by the equation $g(x) = \int_0^x g(t) dt$. It is shown that $g(x)$ is a constant function, and its value is determined by the initial condition $g(0) = 1$.

3. The third part of the paper is devoted to the study of the properties of the function $h(x)$ defined by the equation $h(x) = \int_0^x h(t) dt$. It is shown that $h(x)$ is a constant function, and its value is determined by the initial condition $h(0) = 1$.

4. In the fourth part, we consider the function $k(x)$ defined by the equation $k(x) = \int_0^x k(t) dt$. It is shown that $k(x)$ is a constant function, and its value is determined by the initial condition $k(0) = 1$.

5. The fifth part of the paper is devoted to the study of the properties of the function $l(x)$ defined by the equation $l(x) = \int_0^x l(t) dt$. It is shown that $l(x)$ is a constant function, and its value is determined by the initial condition $l(0) = 1$.

6. In the sixth part, we consider the function $m(x)$ defined by the equation $m(x) = \int_0^x m(t) dt$. It is shown that $m(x)$ is a constant function, and its value is determined by the initial condition $m(0) = 1$.

7. The seventh part of the paper is devoted to the study of the properties of the function $n(x)$ defined by the equation $n(x) = \int_0^x n(t) dt$. It is shown that $n(x)$ is a constant function, and its value is determined by the initial condition $n(0) = 1$.

8. In the eighth part, we consider the function $o(x)$ defined by the equation $o(x) = \int_0^x o(t) dt$. It is shown that $o(x)$ is a constant function, and its value is determined by the initial condition $o(0) = 1$.

9. The ninth part of the paper is devoted to the study of the properties of the function $p(x)$ defined by the equation $p(x) = \int_0^x p(t) dt$. It is shown that $p(x)$ is a constant function, and its value is determined by the initial condition $p(0) = 1$.

10. In the tenth part, we consider the function $q(x)$ defined by the equation $q(x) = \int_0^x q(t) dt$. It is shown that $q(x)$ is a constant function, and its value is determined by the initial condition $q(0) = 1$.

11. The eleventh part of the paper is devoted to the study of the properties of the function $r(x)$ defined by the equation $r(x) = \int_0^x r(t) dt$. It is shown that $r(x)$ is a constant function, and its value is determined by the initial condition $r(0) = 1$.

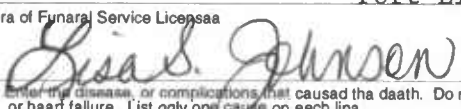

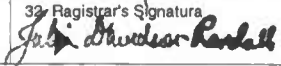
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22483

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Fred Enrico Nardone | | | | 2. Date of Death
Month July Day 2 Year 1997 | | 3. Time of Death
9:00 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Villa Rosa Nursing Home | | | | 4b. City, Town, or Location of Death
Mitchellville | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
160-16-2944 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 5, 1905 | |
| | 9. Birthplace (State or Foreign Country)
Italy | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Upper Marlboro | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3001 Eton Drive | | 10f. Zip Code
20772 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Railroad Worker | | 16b. Kind of Business/Industry
Railroad | | | | |
| 17. Father's Name (First, Middle, Last)
Dominick Nardone | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Rosaria DeBlases | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Robert C. Nardone-Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3001 Eton Drive, Upper Marlboro, Maryland 20772 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. Location - City or Town, State
7-5-97 Brentwood, Maryland | | | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, Maryland 20722 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Acute Dehydration
Due to (or as a consequence of):
b. Unchilled
Due to (or as a consequence of):
c. Upper Gastro-intestinal ulcer.
Due to (or as a consequence of):
d. Compensatory Heart Failure | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D14156 | | 29d. Date signed (Month, Day, Year)
7-2-97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ciro D. Montanero, MD - 1300 Mercantile Lane - Landover MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 08 1997 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

(12)

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BEATRICE V. NICELY

2. Date of Death

Month Day Year
JULY 5, 1997

3. Time of Death

3:31 PM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

232-01-4008

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

NOV. 3, 1910

9. Birthplace (State or Foreign Country)

W. VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8505 SPRINGVALE ROAD

10f. Zip Code

20905

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERICAL

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

ANTONIO ROSANNA

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE CHIDO

19a. Informant's Name/Relationship (Type, Print)

ROBERT NICELY, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4902 HERKIMER STREET, ANNANDALE, VIRGINIA 22003

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY


Date

7/10/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD., BRENTWOOD, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RUPTURED AORTIC ANEURYSM
Due to (or as a consequence of):b. HYPERTENSION
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D50300

29d. Date signed (Month, Day, Year)

July 06, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS J ANTHONY, 11119 ROCKVILLE AVE, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22485

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

BRENDAN MATTHEW NASH

2. Date of Death
Month Day Year

JUN 25 1997

3. Time of Death

5:23 PM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

NONE

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

0

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

2 20

8. Date of Birth
(Month, Day, Year)

JUNE 25, 1997

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12301 FEATHERWOOD DRIVE

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: CAUCASIAN

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

NONE

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

MARK DEWAYNE NASH

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH SCHUTTA

19a. Informant's Name/Relationship (Type, Print)

MARK DEWAYNE NASH - FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12301 FEATHERWOOD DR., SILVER SPRING, MD 20904

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ARLINGTON NATIONAL CEMETERY 7/2/97 ARLINGTON, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Lisa D. Williams

22. Name and Address of Facility

DEMAINE FUNERAL HOMES, INC.
ALEXANDRIA, VA 2231423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SEVERE FETAL ANOMALIES

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

J. Greenwald

29c. License number

D-44634

29d. Date signed (Month, Day, Year)

06/27/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. GREENWALD, CDR, MC, USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

State
Registrar

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

John H. Anderson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study and suggestions for future research.

5. The fifth part of the report is a summary of the main findings of the study. It includes a discussion of the overall conclusions and the significance of the results.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22486

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Lohmann Odell

2. Date of Death

Month Day Year
July 3, 1997

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

7317 Columbia Avenue

4b. City, Town, or Location of Death

Glen Echo

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

124-14-0421

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 28, 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Glen Echo

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7317 Columbia Avenue

10f. Zip Code

20812

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Louis Lohmann

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn Driscoll

19a. Informant's Name/Relationship (Type, Print)

Harry I. Odell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rock Creek Cemetery

Date

7-7-97

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

Eileen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Post necrotic cirrhosis

Due to (or as a consequence of):

b. Immunologic hepatitis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sidney J. Malawer, M.D.

29c. License number

D 07048

29d. Date signed (Month, Day, Year)

July 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sidney J. Malawer, M. D., 10215 Fernwood Road, #401, Bethesda, MD 20817-1184

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22487

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARTIN H. OLSTAD

2. Date of Death

Month JULY Day 5, Year 1997

3. Time of Death

10:50 PM

4a. Facility Name (If not institution, give street and number)

COLLINGTON LIFE CARE

4b. City, Town, or Location of Death

MITCHELLVILLE

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

060-07-0545

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 19, 1904

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10e. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

MITCHELLVILLE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

10450 LOTTSFORD RD. #2015

10f. Zip Code

20716

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CO. PRESIDENT

16b. Kind of Business/Industry

NIAGARA BLOWER CO.

17. Father's Name (First, Middle, Last)

MARTIN T. OLSTAD

18. Mother's Name (First, Middle, Maiden Surname)

AAGOT JESSINE DOVING

19a. Informant's Name/Relationship (Type, Print)

MARTIN D. OLSTAD/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6118 GONDOLIER LN., NEW BERN, N.C. 28560

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHAMBERS CREMATORY

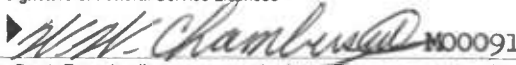
Date

7/7/97

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *ischemic cardiomyopathy*

Due to (or as a consequence of):

b. *renal failure*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. _____

Due to (or as a consequence of):

d. _____

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

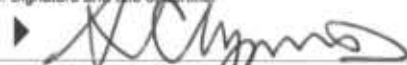
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier



29c. License number

D51085

29d. Date signed (Month, Day, Year)

7/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. Chynna 8911 60th Ave College Park MD 20740

31. Date filed (Month, Day, Year)

JUL 09 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY

REPORT OF THE
COMMISSIONER OF THE GENERAL LAND OFFICE
FOR THE YEAR 1900


CHICAGO, ILL.,
JANUARY 1, 1901.
PUBLISHED BY THE
DIVISION OF THE PHYSICAL SCIENCES,
UNIVERSITY OF CHICAGO.
CHICAGO, ILL., 1901.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22488

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Christopher Todd Orsborne, Sr. | | | | 2. Date of Death
Month July Day 1 Year 1997 | | 3. Time of Death
11:08 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
University of Maryland Shock Trauma Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
218-76-9784 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
38 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sep. 20, 1958 | | |
| | 9. Birthplace (State or Foreign Country)
Kentucky | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Laytonsville | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Montgomery | | | 10c. City, Town or Location
Laytonsville | | | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 10e. Street and Number
7912 Briarheath Court | | | 10f. Zip Code
20882 | | | |
| 10g. Citizen of What Country?
USA | | | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Police Officer | | | 16b. Kind of Business/Industry
Law Enforcement | | | 17. Father's Name (First, Middle, Last)
Donald Orsborne | | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Norma June Baker | | | 19a. Informant's Name/Relationship (Type, Print)
John G. Wood / Father-in-law | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8400 Hawkins Creamery Road, Gaithersburg, Maryland 20882 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | | 20c. Date
7/7/97 | | | |
| 20d. Location - City or Town, State
Silver Spring, Maryland | | | 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | a. Bilateral Basil Ganglia Infarcts | | | 24 hours | | | |
| Due to (or as a consequence of): | | | b. Pulmonary Contusions | | | 72 hours | | | |
| Due to (or as a consequence of): | | | c. Motor Vehicle Accident | | | 80 hours | | | |
| Due to (or as a consequence of): | | | d. | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year)
June 28, 1997 | | 28b. Time of Injury
8:15 PM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred
Motorcycle Accident | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Frederick Rd. and Triadelphia Rd. Howard County | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
AT2438946.B23 | | 29d. Date signed (Month, Day, Year)
July 2, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Eric Wellons University of Maryland Shock Trauma Center, Baltimore, Maryland | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 10 1997 | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22489

Physician
/Medical
Examiner

| | | | | | |
|---|--|---|--|--------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)
LEROY (NMI) OSBORNE | | 2. Date of Death
Month Day Year
JULY 8, 1997 | | 3. Time of Death
1:52 AM | |
| 4a. Facility Name (If not institution, give street and number)
CARROLL COUNTY GENERAL HOSPITAL | | 4b. City, Town, or Location of Death
WESTMINSTER | | 4c. County of Death
CARROLL | |

Funeral
Director

| | | | | | | |
|--|--|---|--------------------------------|--------------------------------|--|---|
| 5. Social Security Number
162-28-0731 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
61 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
AUG. 24, 1935 | 9. Birthplace (State or Foreign Country)
Pa. |
|--|--|---|--------------------------------|--------------------------------|--|---|

Usual Residence of Decedent

| | | | |
|---|------------------------|--|--|
| 10a. State
MARYLAND | 10b. County
CARROLL | 10c. City, Town or Location
TANEYTOWN | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
3630 FRINGER ROAD | | 10f. Zip Code
21787 | 10g. Citizen of What Country?
USA |

| | | | |
|--|---|--|---|
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.
Specify:
CAUCASIAN |
|--|---|--|---|

| | | |
|---|---|--|
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4 or 5+)
2 YEARS | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BOILER&MACHINERY INSPECTOR | 16b. Kind of Business/Industry
INDUSTRIAL INSURANCE COMPANY |
|---|---|--|

| | |
|---|---|
| 17. Father's Name (First, Middle, Last)
LESLIE OSBORNE | 18. Mother's Name (First, Middle, Maiden Surname)
CHARLOTTE HUGHES |
|---|---|

| | |
|--|--|
| 19a. Informant's Name/Relationship (Type, Print)
ELAINE J. OSBORNE WIFE | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3630 FRINGER ROAD TANEYTOWN, MARYLAND 21787 |
|--|--|

| | | |
|---|--|--|
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. JOSEPH'S R.C. CEMETERY | 20c. Location - City or Town, State
TANEYTOWN, MARYLAND |
|---|--|--|

| | |
|--|--|
| 21. Signature of Funeral Service Licenses
P. Kevin Judy | 22. Name and Address of Facility
136 EAST BALTIMORE STREET
SKILES FUNERAL HOME TANEYTOWN, MARYLAND 21787 |
|--|--|

| | |
|--|---|
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Cerebral metastases
Due to (or as a consequence of):
Adeno carcinoma of unknown origin
Due to (or as a consequence of):
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
10/96 |
|--|---|

| | |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|--|--|

| | |
|---|---|
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|

| | |
|---|---|
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
|---|---|

| | | | | |
|---|--|--------------------------|--|-----------------------------------|
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day Year)
M | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how Injury occurred |
|---|--|--------------------------|--|-----------------------------------|

| | |
|--|--|
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|--|--|

| | | | |
|--|---|-------------------------------|---|
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29b. Signature and title of certifier
Rolando Vieta MD | 29c. License number
D17150 | 29d. Date signed (Month, Day, Year)
JULY 9, 1997 |
|--|---|-------------------------------|---|

| |
|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROLANDO VIETA, M.D. 1447 YORK ROAD LUTHERVILLE, MARYLAND 21093 |
|--|

| | |
|--|--|
| 31. Date filed (Month, Day, Year)
JUL 09 1997 | 32. Registrar's Signature
John Davidson-Randall |
|--|--|

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22490

| | | | | | | |
|--|---|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Maria Francisca Pena</i> | | 2. Date of Death
Month <i>July</i> Day <i>4</i> Year <i>97</i> | | 3. Time of Death
<i>12:14 PM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>2103 Greenery Lane, #302</i> | | 4b. City, Town, or Location of Death
<i>Silver Spring</i> | | 4c. County of Death
<i>Montgomery</i> | |
| Funeral
Director | 5. Social Security Number
<i>577-74-5613</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>68</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
<i>May 24, 1929</i> | | 9. Birthplace (State or Foreign Country)
<i>El Salvador</i> | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location
<i>Washington, D.C.</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10a. State | 10b. County | | | | |
| | 10e. Street and Number
<i>3217 Connecticut Avenue, N.W., #67</i> | | 10f. Zip Code
<i>20008</i> | | 10g. Citizen of What Country?
<i>USA</i> | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <i>El Salvador</i> | |
| | 14. Race - American Indian, Black, White, etc.
Specify: <i>Hispanic</i> | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> Collage (1-4 or 5+) <i>2</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Nurse</i> | | 16b. Kind of Business/Industry
<i>Medical</i> | |
| | 17. Father's Name (First, Middle, Last)
<i>Jose Pena</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Luisa Pena</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Maria E. Pena / Sister</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2103 Greenery Lane, #302, Silver Spring, MD 20906</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Gate of Heaven Cemetery</i> | | 20c. Location - City or Town, State
<i>Silver Spring, Maryland</i> | |
| | 21. Signature of Funeral Service Licensee
<i>Lani J. Holland</i> | | 22. Name and Address of Facility
<i>Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904</i> | | | |
| Physician
/Medical
Examiner | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death | |
| | Immediate Cause (Final disease or condition resulting in death)
a. <i>acute myocardial infarction</i> | | | | <i>10 mins</i> | |
| | Due to (or as a consequence of): | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | | | | |
| | | c. Due to (or as a consequence of): | | | | |
| | | d. Due to (or as a consequence of): | | | | |
| | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. Signature and title of certifier
<i>John Tauber MD</i> | | 29c. License number
<i>D08546</i> | | 29d. Date signed (Month, Day, Year)
<i>July 5 1997</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>John Tauber 8218 Wisconsin Ave Bethesda Md.</i> | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>JUL 8 1997</i> | | 32. Registrar's Signature
<i>Julia Davidson-Randall</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

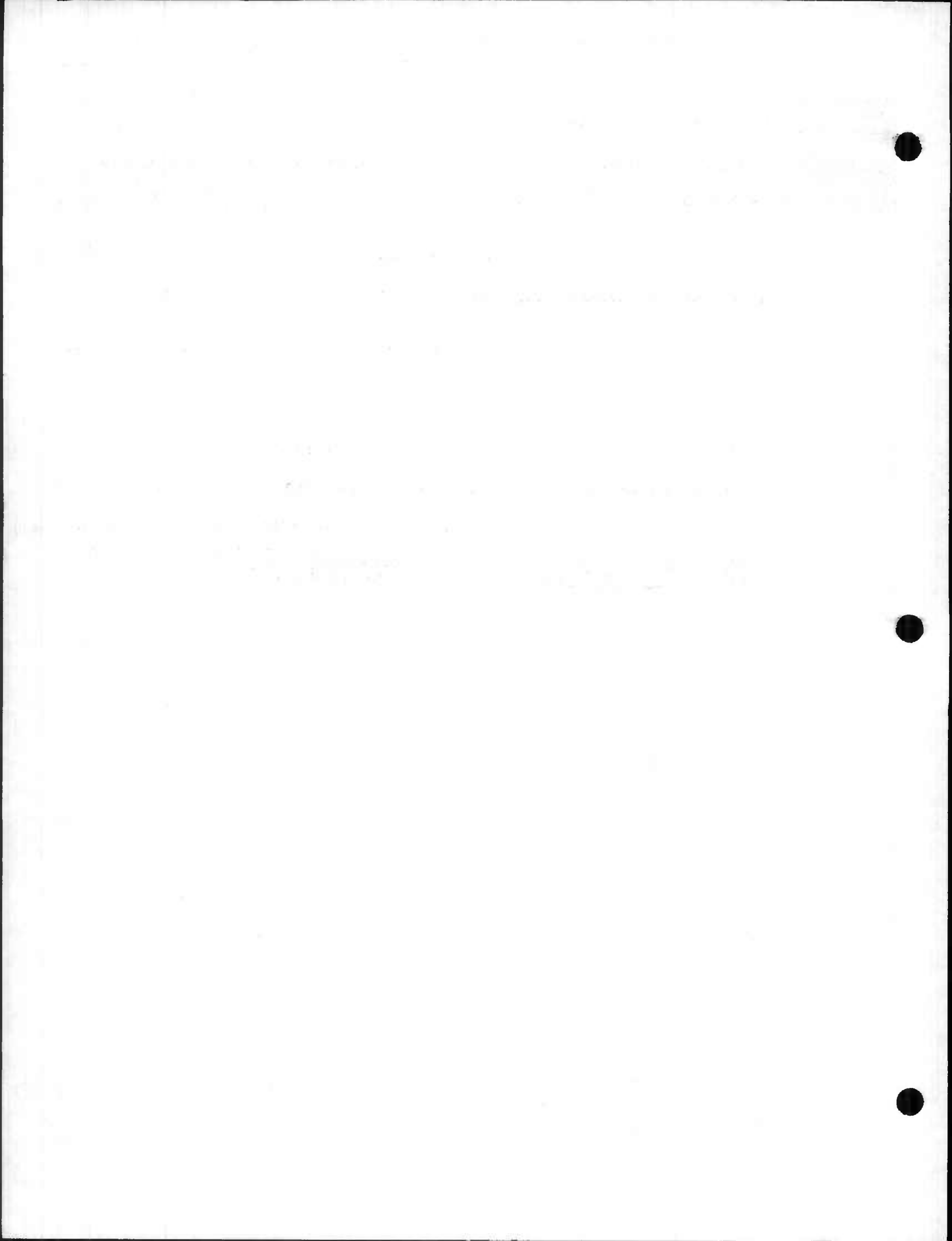
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22491

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hjordis Peterson

2. Date of Death

Month 7 Day 1 Year 97

3. Time of Death

6:45 PM

4a. Facility Name (If not institution, give street and number)

Springbrook Nursing Center 12325 N.H. Ave

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

360-14-7332

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
1-22-10

9. Birthplace (State or Foreign Country)

Sweden

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12325 New Hampshire Avenue

10f. Zip Code

20904

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Swen Ebbeson

18. Mother's Name (First, Middle, Maiden Summa)

Ida Sweenson

19a. Informant's Name/Relationship (Type, Print)

Keith Peterson - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4616 Edgefield Road Bethesda, MD 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Comfort Crematory

Date

7/3/97

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Joseph Gawler's Sons

5130 Wisc. Ave. N.W. Washington, D. C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC ENDOMETRIAL CARCINOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~ 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D-17874

29d. Date signed (Month, Day, Year)

7-1-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. M. NAYAR, MD 3717-38th Ave COTTAGE CITY, MD 20722

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22492

| | | | | | | | | |
|---|--|---|---|--------------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDYTHE B. PLUMMER | | | | 2. Date of Death
Month JULY Day 5 , Year 1997 | | 3. Time of Death
5:25 A | |
| | 4a. Facility Name (If not institution, give street and number)
Shady Grove Nursing & Rehab Center | | | | 4b. City, Town, or Location of Death
Rockville | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
214-36-3598 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 18, 1918 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Gaithersburg | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
9519 Stewarttown Road | | 10f. Zip Code
20879 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> Collega (1-4 or 5+) <input checked="" type="checkbox"/> 2 yrs | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
None | | | |
| | 17. Father's Name (First, Middle, Last)
Robert L. Prather | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Hester Claggett | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Yvonne P. King (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9519 Stewarttown Rd., Gaithersburg, MD 20879 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brooke Grove Ce., | | 20c. Location - City or Town, State
7/10/97 Laytonsville, MD | | | |
| | 21. Signature of Funeral Service licensee
<i>George R. Prather</i> | | | | 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Cerebrovascular accident</p> <p>Due to (or as a consequence of):</p> <p>b. Diabetes Mellitus</p> <p>Due to (or as a consequence of):</p> <p>c. Hypertension</p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>YRS</p> <p>YRS.</p> <p>YRS.</p> </div> </div> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>George R. Prather</i> | | | | 29c. License number
D35792 | | 29d. Date signed (Month, Day, Year)
JULY, 7, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SWAROOP G. KAO, 50, W. EDMONSTON DR, ROCKVILLE, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 08 1997 | | 32. Registrar's Signature
<i>Julia Davidson-Russell</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22493

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jose R. Pocasangre

2. Date of Death

Month Day Year

July 4 1997

3. Time of Death

1:45 AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-72-9794

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 5, 1925

9. Birthplace (State or Foreign Country)

El Salvador

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8133 15th Avenue #3

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: El Salvadorian

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Musician

16b. Kind of Business/Industry

Entertainment

17. Father's Name (First, Middle, Last)

Jose Contreras

18. Mother's Name (First, Middle, Maiden Surname)

Clementina Pocasangre

19a. Informant's Name/Relationship (Type, Print)

Juana Pocasangre

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8133 15th Avenue #3 Hyattsville, Maryland 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/07/97

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Edu S. Scurlo

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

6 Weeks

b. Sepsis/Pneumonia

Due to (or as a consequence of):

6 Weeks

c. Metastatic Cancer of Stomach

Due to (or as a consequence of):

7 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Radman Mostaghim, M.D.

29c. License number

046093

29d. Date signed (Month, Day, Year)

7/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Radman Mostaghim, M.D. 7305 Hanover Parkway Greenbelt, Maryland 20770

31. Date filed (Month, Day, Year)

JUL 07 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject.

2. The second part of the report is a detailed description of the methods used.

3. The third part of the report is a discussion of the results obtained.

4. The fourth part of the report is a conclusion and summary of the findings.

5. The fifth part of the report is a list of references.

6. The sixth part of the report is a list of figures and tables.

7. The seventh part of the report is a list of appendices.

8. The eighth part of the report is a list of acknowledgments.

9. The ninth part of the report is a list of footnotes.

10. The tenth part of the report is a list of symbols and abbreviations.

11. The eleventh part of the report is a list of equations.

12. The twelfth part of the report is a list of definitions.

13. The thirteenth part of the report is a list of units.

14. The fourteenth part of the report is a list of constants.

15. The fifteenth part of the report is a list of variables.

16. The sixteenth part of the report is a list of parameters.

17. The seventeenth part of the report is a list of quantities.

18. The eighteenth part of the report is a list of properties.

19. The nineteenth part of the report is a list of characteristics.

20. The twentieth part of the report is a list of features.

21. The twenty-first part of the report is a list of attributes.

22. The twenty-second part of the report is a list of qualities.

23. The twenty-third part of the report is a list of quantities.

24. The twenty-fourth part of the report is a list of properties.

25. The twenty-fifth part of the report is a list of characteristics.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 22494

Reg. No.

| | | | | | | | | | |
|---|--|-------------------------------|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Perry Mark Patterson | | | | | 2. Date of Death
Month July Day 7 Year 1997 | | 3. Time of Death
9:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
501 Old Robin Hood Road | | | | | 4b. City, Town, or Location of Death
Aberdeen | | 4c. County of Death
Harford | |
| Funeral
Director | 5. Social Security Number
217-70-7394 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
43 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 14, 1954 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Harford | | 10c. City, Town or Location
Aberdeen | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
501 Old Robin Hood Road | | | | | 10f. Zip Code
21001 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+ | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Engineering Psychologist | | 16b. Kind of Business/Industry
U.S. Government | | |
| 17. Father's Name (First, Middle, Last)
Kenneth Howard Patterson | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bernice Eileen Passmore | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Pamela Lyons (Sister) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1515 Castleton Road, Darlington, Maryland 21034 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
R. A. Ferris & Co., Inc. | | Date
7/9/97 | | 20c. Location - City or Town, State
West Chester, PA | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ADENOCARCINOMA of UNKNOWN PRIMARY
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | Approximate Interval Between Onset and Death
20 MONTHS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
D 31775 | | 29d. Date signed (Month, Day, Year)
July 8, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John P. Edwards, M.D. | | | 31. Date filed (Month, Day, Year)
JUL 9 1997 | | | | | | |
| | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 22495

MICHELLE C. POWELL

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Michelle Atkinson Powell | | | | 2. Date of Death
Month Day Year
JULY 11 1997 | | 3. Time of Death
10:30AM | |
| | 4a. Facility Name (If not Institution, give street and number)
2206 HOPE CIRCLE | | | | 4b. City, Town, or Location of Death
WALDORF | | 4c. County of Death
CHARLES | |
| Funeral
Director | 5. Social Security Number
214 08 7554 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
27 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb 25, 1970 | |
| | 9. Birthplace (State or Foreign Country)
Washington D.C. | | 10a. State
Maryland | | 10b. County
P.G. | | 10c. City, Town or Location
Clinton | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
5809 Terence Drive | | 10f. Zip Code
20735 | |
| | 10g. Citizen of What Country?
United States | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Physician
/Medical
Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Investigative Analyst | | | | 16b. Kind of Business/Industry
FBI Federal Government | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Sinclair E. Atkinson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gladys Houston | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Gladys Watkins | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5809 Terence Dr. Clinton, Maryland 20735 | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Cemetery | | 20c. Location - City or Town, State
Suitland, Maryland | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head injury. List only one condition on each line.
Multiple Gunshot Wounds | | | | Approximate Interval Between Onset and Death | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
AT HOME | | | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 28a. Date of Injury (Month, Day Year)
UNK | | | | 28b. Time of Injury
UNK M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred
Subject shot | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
2206 Hope Circle 20601 | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | |
| | 29c. License number
O.C.M.E. | | | | 29d. Date signed (Month, Day, Year)
JULY 12, 1997 | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LARON WATKINS, MD | | | | 31. Data filed (Month, Day, Year)
JUL 15 1997 | | | |
| | 32. Registrar's Signature
<i>[Signature]</i> | | | | 33. Registrar's Name
John Davidson Randall | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22496

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

IRENE ELIZABETH PAUL

2. Date of Death

JULY 12, 1997

3. Time of Death

10:15PM

4a. Facility Name (If not institution, give street and number)

PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

5. Social Security Number

578-34-4173

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

8. Date of Birth (Month, Day, Year)

JULY 10, 1911

9. Birthplace (State or Foreign Country)

AQUASCO, MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

LAPLATA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1 MAGNOLIA AVENUE

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

NATHAN WILKERSON

18. Mother's Name (First, Middle, Maiden Surname)

IRENE ELIZABETH WILKERSON

19a. Informant's Name/Relationship (Type, Print)

LEW E. PAUL, JR / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

307 TAYLOR ST. FREDERICKSBURG VIRGINIA 22405

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. PETERS CHURCH CEM.

Data

7-15-97

20c. Location - City or Town, State

WALDORF, MARYLAND

21. Signature of Funeral Service Licensee

SHANNON W. RAMIREZ M00798

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.

P.O. BOX 156 WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-20629

29d. Date signed (Month, Day, Year)

7/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE WATHEN MD 11345 PEMBROOKE SQUARE SUITE 103 WALDORF, MD 20603

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

John Andrew Randall

State
RegistrarIRENE PAUL
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

22497

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT CHARLES PUSEY, SR.

2. Date of Death

Month Day Year
JULY 13, 1997

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

30002 BARGER DRIVE

4b. City, Town, or Location of Death

MECHANICSVILLE

4c. County of Death

ST. MARY'S

Funeral
Director

5. Social Security Number

577-32-7823

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

APRIL 27, 1928

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ST. MARY'S

10c. City, Town or Location

MECHANICSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

30002 BARGER DRIVE

10f. Zip Code

20659

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: KOREA

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

UPHOLSTERER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

ROBERT PUSEY

18. Mother's Name (First, Middle, Maiden Surname)

SOPHIE MARIE BECK

19a. Informant's Name/Relationship (Type, Print)

SHARON D. PUSEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TRINITY MEM. GARDEN 7-16-97 WALDORF, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael O. L...

22. Name and Address of Facility

RAYMOND FUNERAL SERVICE
LA PLATA, MARYLAND 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Lung Cancer, metastatic to brain
Due to (or as a consequence of): bone, liver, adrenal

Approximate Interval Between Onset and Death

Months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Larry Jenkins, Jr.

29c. License number

D33426

29d. Date signed (Month, Day, Year)

7/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Larry Jenkins, Jr., M.D., PO Box 1724, LaPlata, MD 20646

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

Julia Davidson Randall

State
Registrar

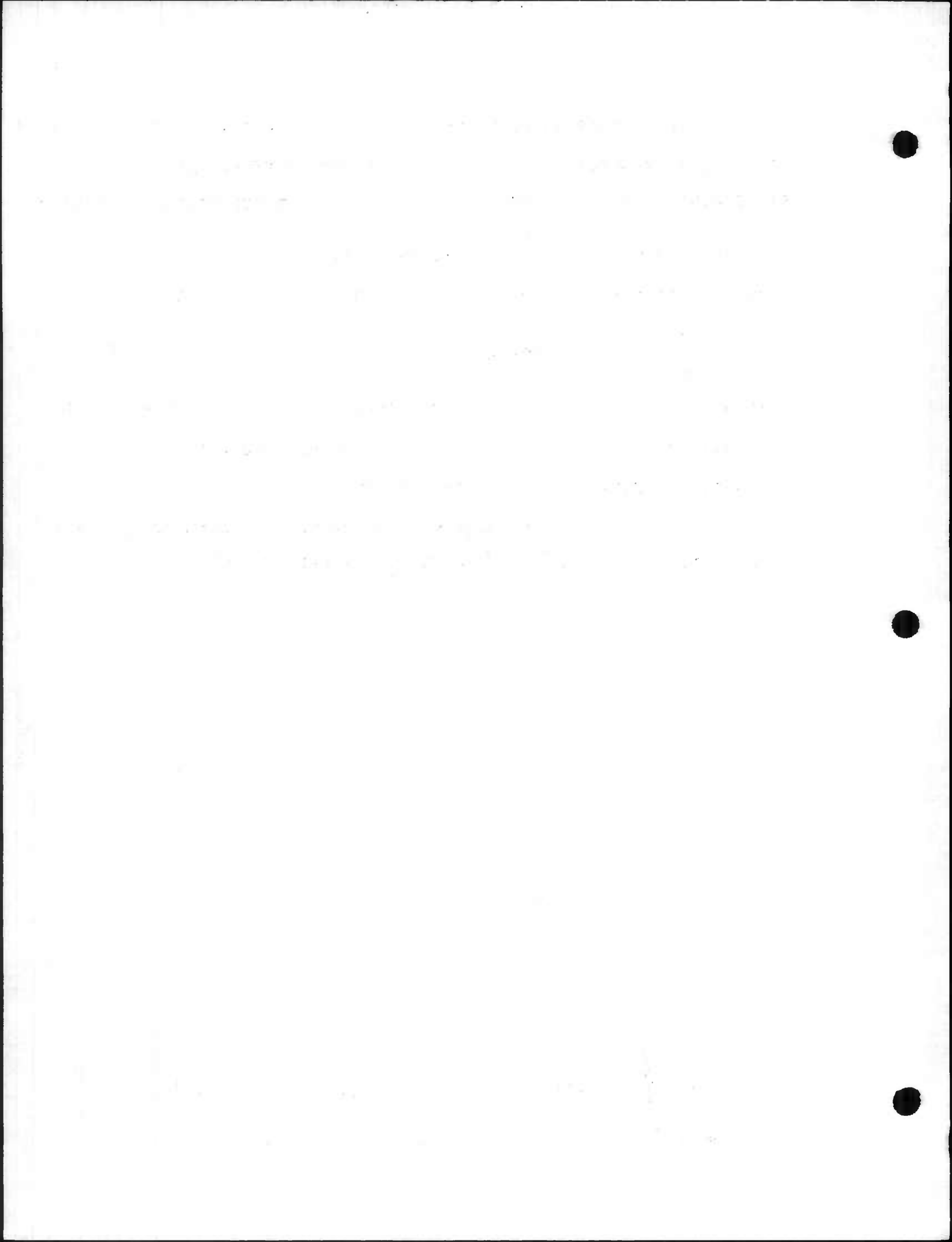
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 905-58.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 22498

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH

POOLE

2. Date of Death

Month

Day

Year

JULY 10, 1997

3. Time of Death

00:10

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

235 38 0040

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Mar. 28, 1927

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

250 Laurel Drive

10f. Zip Code

20657

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married2 ☐ Married3 ☒ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Clarence C. Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Estella Mae Owens

19a. Informant's Name/Relationship (Type, Print)

Debrah D. Robey / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as # 10 above

20a. Method of Disposition

1 ☐ Burial2 ☒ Cremation3 ☐ Removal from State4 ☐ Donation5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

7-11-97

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

William R. Jones

22. Name and Address of Facility

Rausch Funeral Home, P.A.

4405 Broomes Is. Rd., Port Republic, MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

days

c. Lung Carcinoma

Due to (or as a consequence of):

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael D. Lee

29c. License number

D38991

29d. Date signed (Month, Day, Year)

July 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL D. LEE, 120 HOSPITAL ROAD, PRINCE FREDERICK MD 20678

31. Date filed (Month, Day, Year)

JUL 11 1997

32. Registrar's Signature

Julia Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Movita E. Pickens

2. Date of Death

Month Day Year
July 10 1997

3. Time of Death

11:04 PM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

233-60-4683

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11/11/39

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3488 Olympia Rd.

10f. Zip Code

21035

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Coordinator of Guidance

16b. Kind of Business/Industry

System
Anne Arundel Co. School

17. Father's Name (First, Middle, Last)

Karl Ellcessor

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Sharp

19a. Informant's Name/Relationship (Type, Print)

Roger L. Pickens/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 7/13/97

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, Md. 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.

Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure

Approximate Interval Between Onset and Death

2 hours

e.

Due to (or as a consequence of):

Pulmonary edema

2 hours

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lymphoma

s/p bone marrow transplant

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

019838

29d. Date signed (Month, Day, Year)

7/12/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stuart E. Selonick, M.D. 900 Bestgate, Annapolis Md. 21401

31. Date filed (Month, Day, Year)

JUL 14 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 22500

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Isabell Palmer

2. Date of Death

Month Day Year
July 8, 1997

3. Time of Death

11:33p.m.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

578-38-8945

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 11, 1909

9. Birthplace (State or Foreign Country)

Nova Scotia

Usual Residence of Decedent

10a. State
Maryland10b. County
Prince George's10c. City, Town or Location
Mount Rainier

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3306 Shepard Street

10f. Zip Code

20822

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Philippe LeBlanc

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Kathleen Ropko - Step daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8901 60th avenue, Berwyn Heights, Maryland 20740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

08/11/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Henry S. Ford

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
Hyattsville, Maryland 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. BRAIN INFARCT - ACUTE
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. ATHEROSCLEROTIC VASCULAR DISEASE
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

Mario Belledonne M.D.

29c. License number

D23177

29d. Date signed (Month, Day, Year)

07/09/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mario Belledonne M.D. 121 Congressional Lane #205, Rockville, Maryland

31. Date filed (Month, Day, Year)

JUL 10 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

